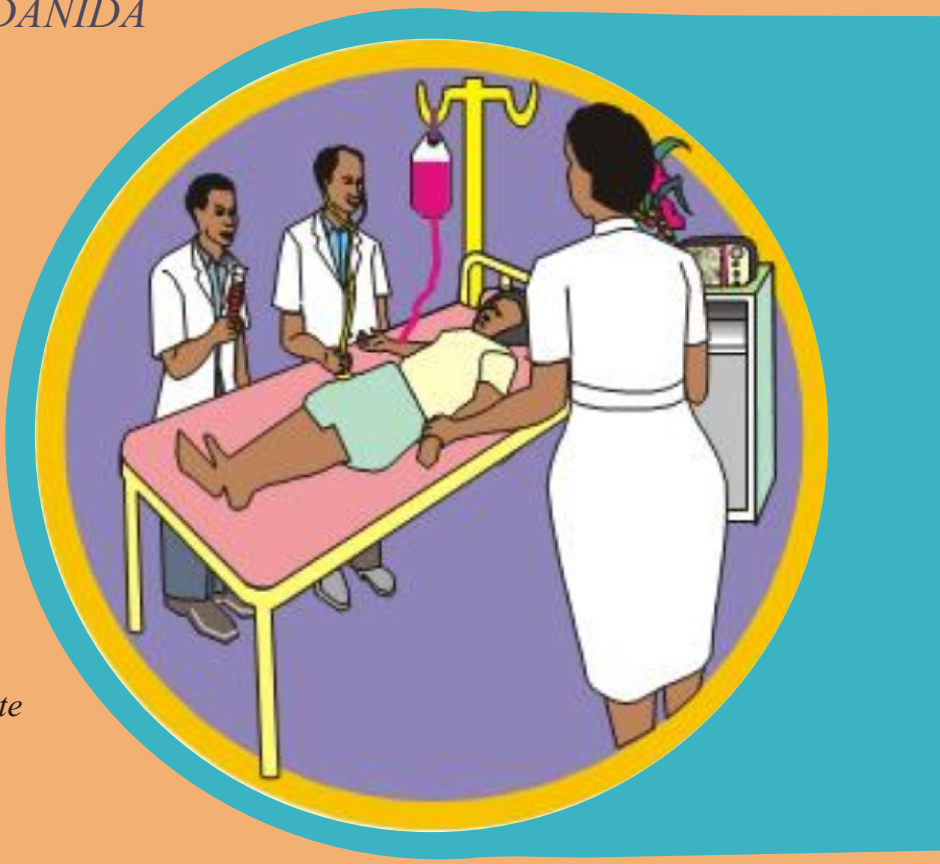
HEALTHCARE QUALITY ASSURANCE MANUAL

FOR SUB-DISTRICTS
JULY 2004

WITH SUPPORT FROM DANIDA



Contributors:

Dr Aaron K. Offei
Central Regional Health Directorate

Dr. Cynthia Bannerman
Institutional Care Division
Ghana Health Service

Mr. Kumi Kyeremeh
Eastern Regional Health Directorate

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PREFACE

Patients and Clients often complain about poor quality of services in our health facilities.

Poor quality is costly; it leads to loss of lives, loss of time, loss of public confidence, low staff morale and also results in wastage of our limited resources.

The Ghana Health Service has as one of its main objectives, the improvement in quality of care at all service delivery points. It is the responsibility of all health workers to help achieve this objective.

This manual was written by local experts for health workers especially those delivering service at the sub-district level to provide them with the essential knowledge and skills to plan and implement quality assurance in their health facilities.

For those in the sub-district this manual will:

- Introduce them to the concept of quality and its components
- Provide practical steps to implement Quality Assurance at the sub-district level

It is also a useful manual for in-service and pre-service training programmes. The manual will also be useful as a reference document.

Professor Agyeman Badu Akosa
Director General
Ghana Health Service

ACKNOWLEDGEMENTS

The authors are grateful to the Director General of the Ghana Health Service, Professor Agyeman Badu Akosa for entrusting them with the assignment of writing this manual.

We also thank the Danida Health Office in Accra for providing financial support to the project. We are particularly grateful to the Senior Health Advisor, Dr Kobina Bainson for his useful suggestions.

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The authors are also grateful to those who read through the draft manual and offered invaluable suggestions. They are Justice Hafoba, Dinah Baah-Odoom, Florence Offei, Dr. S. M. Zakariah and Bertha Boakye Agyeman.

Finally, we are looking forward to receiving comments from health workers who use the manual . Their feedback will go a long way to help improve on future reviews.

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INTRODUCTION TO THE MANUAL

Patients often complain about the poor quality of the services they receive at our health facilities. Poor quality causes loss of lives, loss of revenue, low morale among health workers and poor image of health care providers.

In Ghana, improving the quality of healthcare is a key objective of the Ministry of Health and the Ghana Health Service. One of the strategies for achieving this is through the implementation of quality assurance programmes in all health facilities. It is envisaged that quality assurance will become an integral part of routine health service delivery in Ghana

Quality Assurance (QA) started in the Eastern and Upper West regions with the support of Liverpool School of Tropical Medicine and Danish International Development Agency (DANIDA). Most of the regions have quality assurance programmes although they are all at different stages of implementation. However, the Implementation of quality assurance at the sub-district level is rather low.

This manual is targeted at health center and clinic staff at the sub-district in both the private and public sectors. Its main objective is to raise awareness about the importance of quality assurance in everyday work situations. It focuses on essential knowledge needed to plan and establish quality assurance in the health facility. It is also useful for the training of health workers at the sub-district level.

The manual is useful in the training of staff involved in both clinical and public health activities. Health training institutions will find it beneficial in the teaching of the concept, principles and processes of quality assurance. The manual is also a useful guide for managers supervising the implementation of quality assurance programmes

Chapters 1 and 2 looks at Quality and Quality Assurance.
Chapters 3 and 4 discuss the role of health providers and clients in Quality Assurance.
Chapters 5,6 and 7 shows how we can monitor quality and improve on the care we give.
Chapters 8,9 and 10 discuss how to improve and sustain quality in the delivery of health care.
Chapter 8 teaches us the steps involved in improving quality.
Chapter 9 shows us how to implement QA in the clinics.
Chapter 10 discusses how to get every member of staff involved.

1

THE CONCEPT OF QUALITY

1.0 Introduction

Our patients/clients and the general public often complain about the poor quality of care in our health facilities. We often hear on the radio, television and even in the community about the poor quality of care that patients have received from us. We ourselves experience this poor quality in our health facilities when we are sick. Although we have few resources and may be short of staff, we can do something about the poor quality of healthcare.

At the end of this chapter you will be able to

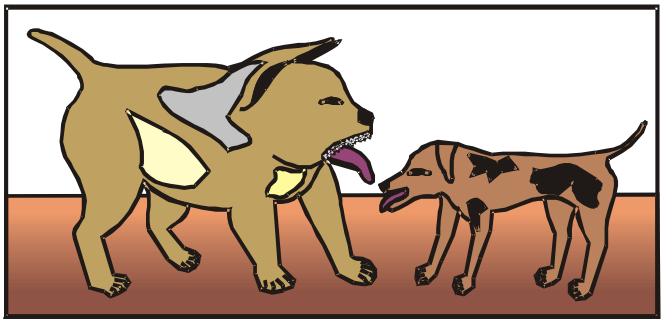
- ✍ Explain what quality means
- ✍ Explain the meaning of quality of care
- ✍ State and explain the various aspects of quality health service
- ✍ Discuss the patient's/client's, health manager's and health worker's view about quality

1.1 What Is Quality?

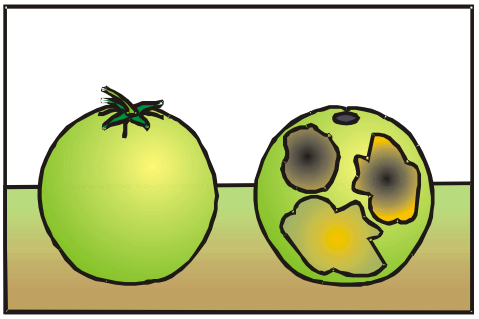
To the ordinary person, quality is how good something is. This may be a service e.g. canteen service or a product eg. wrist watch. A person's judgement about a service or product depends on what he expects of it or from it. Some of the words used to describe quality are:

- ✍ Beautiful or attractive
- ✍ Durable
- ✍ Meeting standards
- ✍ Healthy
- ✍ Value for money

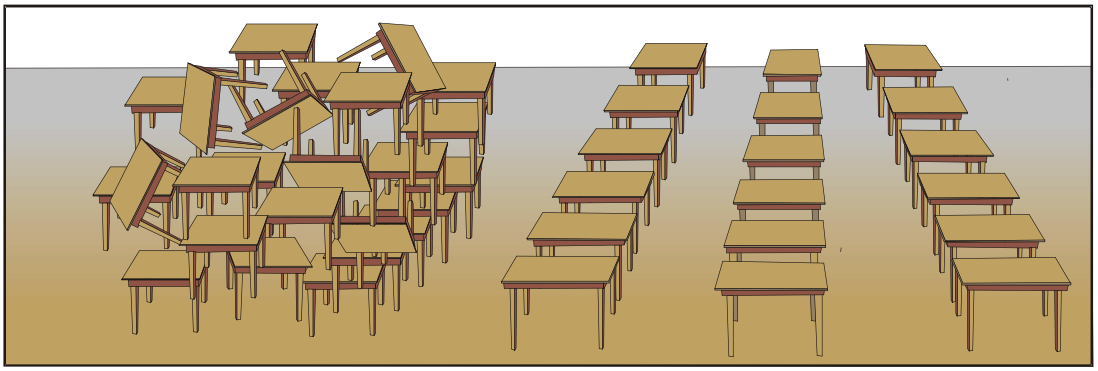
Although different words are used to explain quality, we would define it as **the extent to which a product or service satisfies a person or a group** i.e. how much satisfaction the person gets from the service.



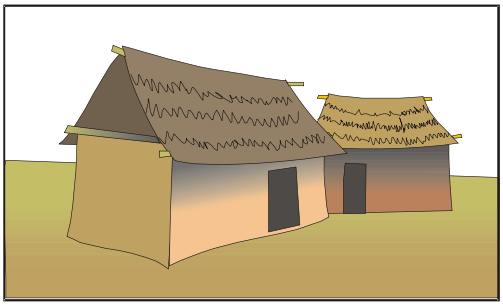
A: A Healthy and an unhealthy dog



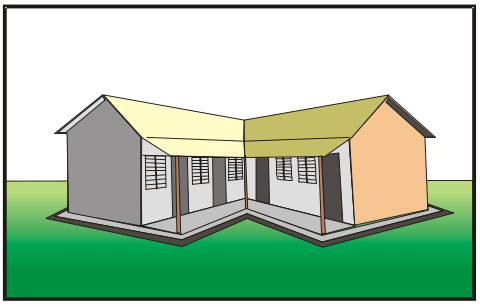
B: A fresh and rotten oranges



C: Disordered and neatly arranged tables



D: Thatch structures



E: Beautiful building with well-kept environment

Fig. 1: Different structures showing levels of quality

People's expectations differ. Therefore, what Ama expects from a service may be different from what Kofi expects of it. Also with time, Ama's expectations may change therefore it is very important that we keep on improving on the quality of our services

1.2 What is Quality of Care?

When we say quality of care, we mean healthcare activities that we in the medical, nursing, laboratory fields etc. perform daily to benefit our patients without causing harm to them. Quality of Care demands that we pay attention to the needs of patients and clients. We also have to use methods that have been tested to be safe, affordable and can reduce deaths, illness and disability. Furthermore, we are expected to practice according to set standards as laid down by clinical guidelines and protocols.

With Quality of Care we do the right things at the right time. We see to patients promptly, make the right diagnosis and give the right treatment. With quality of care we keep on improving on our standard of services till excellence is attained.

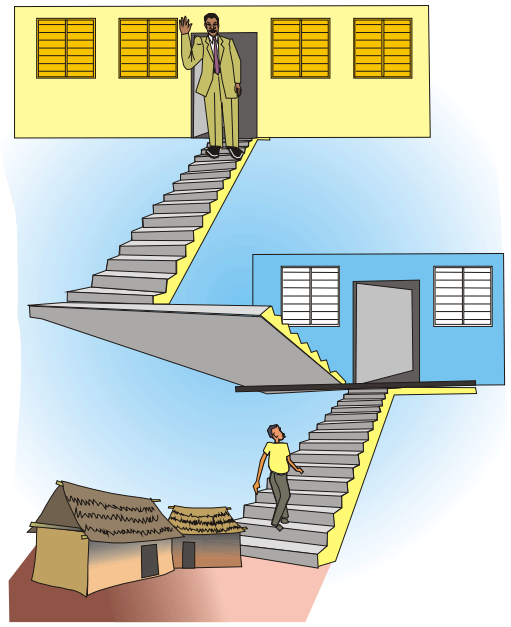


Fig. 2: Climbing steadily towards achieving excellence in quality

1.3 Components of Quality Health Services

Quality health service has several parts. We need to understand these in order to improve quality of care. The parts are listed in the box below. We shall look briefly at each of the parts.

Access	Efficiency
Technical competence	Continuity
Equity	Safety
Effectiveness	Amenities

1.3.1 Access to Service

Everyone should have access to quality health care. Access refers to the ability of the individual to obtain health services. Some of the factors that can affect access are:

a) Distance: e.g. where health facility is sited far away or it is difficult to get transport to the facility access to quality health care becomes a problem.

b) Financial: e.g. where people cannot pay for the services provided.

c) Culture, beliefs and values: The services provided may not be in line with the culture, beliefs and values of some people.

1.3.2 Technical Competence

Technical competence as an indicator of quality assurance implies that we should have adequate knowledge and skills to carry out our functions in order to provide quality service. E.g. one must go to a nursing school and pass the nursing examinations before she can work as a nurse.

Even though we are no longer in school, we have to continue to update our knowledge by reading health books and attending in-service training workshops etc.

As health professionals, we should also know our limits, that is, know what we can do and what we cannot do. With respect to what we cannot do, we are expected to refer them to other centres or personnel who are more competent to handle them.

Our practice should also be guided by laid down standards and guidelines e.g. Standard Treatment Guideline.

1.3.3 Equity

Quality services should be provided to all people who need them, be they poor, children, adults, old people, pregnant women, disabled etc. Quality services should be available in all parts of the country, in villages, towns and cities.

1.3.4 Effectiveness

We are interested in the type of care that produces positive change in the patient's health or quality of life. We therefore use treatments that are known to be effective, for example, giving a child with diarrhea Oral Rehydration Salt (ORS)

1.3.5 Efficiency

Efficiency is the provision of high quality care at the lowest possible cost. We are expected to make the best use of resources and avoid waste of our scarce resources. We waste resources by :

- prescribing unnecessary drugs
- stocking more drugs than is required and making them expire
- buying supplies and equipment we do not use

What happens when we stock more drugs than is required?

1.3.6. Continuity

Continuity means that the client gets the full range of health services he/she needs, and that when the case is beyond us, we refer him/her to the right level for further care.

Continuity may be achieved by the patient seeing the same primary health care worker or by keeping accurate health records so that another staff can have adequate information to follow up the patient.

1.3.7 Safety

Safety means that when providing health services, we reduce to the barest minimum injuries, infections, harmful side effects and other dangers to clients and to staff. In providing quality care, we should not put the patient's life at risk. For example, we should not give unsafe blood to patients and thereby infect them with HIV/AIDS.

1.3.8. Interpersonal Relations

It refers to the relationship between us and our clients and communities, between health mangers and their staff.

We should:

- show respect to our clients;
- feel for our patients;
- not be rude or shout at them;
- not disclose information we get from patients to other people.

These will bring about good relations and trust between the clients/communities and us. Clients consider good interpersonal relationship as an important component of quality of care.

1.3.9 Amenities

These are features that can be provided by our health facilities to make life comfortable and pleasant for clients. They contribute to clients' satisfaction and make clients willing to use our services. For example, comfortable seats, television sets, music, educational materials, educative video films, etc. at the OPD and wards.

1.4 Perspectives of Quality

The health staff, health manager, clients and communities are all stakeholders in service delivery. Each of these groups may expect different things from health services.

1.4.1 The Patient/Client

Research done in various parts of the country shows that our patients/clients want services that:

- are delivered on time by friendly and respectful staff;
- are safe, produce positive result and that they can afford;
- provide them with adequate information about their condition and treatment;
- provide them with all the drugs they need;
- give privacy.
- are within their reach (distance) and given in a language they can understand.

1.4.2 The Health Staff Provider

The health provider can provide quality care if he/she has:

- adequate knowledge and skills.
- enough resources- staff, drugs, supplies, equipment and transport etc
- safe and clean workplace.
- opportunity to regularly improve himself/herself.
- is well paid and rewarded for good work.

1.4.3 The Health Care Manager

The health care manager sees quality care as:

- managing efficiently the resources of the health facility.
- health staff achieving set targets.
- health staff being regularly supported and supervised.
- having adequate and competent staff to provide care.
- staff being disciplined.
- providing enough resources for work.

1.5 Other ways of understanding Quality

We will now look at some other ways of understanding quality. Quality of care can also be seen from the inputs, processes and outcome of service delivery. We have to address these together to improve on quality.

Most of the time we only complain about lack of inputs without also looking at how we do things or activities that we carry out.

1.5.1 Inputs

These are materials needed to provide care. Examples include staff, drugs, buildings and equipment.

1.5.2 Process

This refers to what is done and the way things are done. An example is the activities for outpatient care. The patient has to make a card, go to the screening table for his/her temperature and blood pressure to be taken. He/she then goes to the consulting room after which he/she goes to the dispensary for drugs.

1.5.3 Output/Outcome

It is the results we get out of health service delivery. For example, is the client satisfied with the service he/she gets after visiting our facility? Has there been a decrease in outpatient attendance?

Answers to the two questions are indications of output/ outcome of our health service delivery.

Chapter Summary

In this chapter, we have discussed the meaning of quality from different angles.

We can look at quality from its various components or parts-access, technical competence, amenities, equity, efficiency, effectiveness, safety, continuity of services and interpersonal relationship.

We can also explain quality from the point of view of the perspectives of various stakeholders in health care-the patient/client, the health staff and the manager.

Quality can also be discussed from the inputs, processes and output/outcomes of service delivery.

Exercise

From your outpatient services, make a list of things that can be considered under the following headings; Inputs, Processes, and Outputs. Show how the listed factors affect health service delivery.

2

THE CONCEPT OF QUALITY ASSURANCE

2.0 Introduction

We now know what quality of care means, the different components and the different views. In this chapter, we will learn about quality assurance, the benefits and barriers to quality assurance. We shall also learn about the cost of poor quality.

When you go through this chapter, you should be able to:

- explain what quality assurance is
- describe the five principles of quality assurance
- discuss the benefits of quality assurance
- discuss the cost of poor quality that occurs in your health facility.

2.1 What Is Quality Assurance?

Quality Assurance (QA) started long ago in Japanese industry. It was realized that through inspection, more faulty products were detected but the quality of the products did not change. It became necessary therefore to look at the ways products were made so that any changes can be made along the line before the finished product came out. Therefore quality assurance was adopted from industry into the health care setting in the developed countries. It has really helped in improving quality of care in these countries. Now we in Ghana have also adopted quality assurance to improve health service delivery.

Quality Assurance is a set of activities that are planned for, carried out systematically or in an orderly manner and continuously to improve quality of care. It involves:

- The setting of standards;
- Monitoring to see if there is a gap between what is being done now and what is expected; and addressing the gap on a regular basis (quality improvement).

Quality Assurance encourages health workers to examine the services they provide, assess their own work and come out with what they can do with the limited resources to improve the quality of care.

For supervisors and managers, QA calls for change from the status of an inspector to that of a facilitator, and expects the health workers to identify and solve problems.

Quality Assurance also requires that health workers understand the needs of patients and their communities in order to provide for them.

Quality Assurance requires active support and commitment from leaders at the national, regional, district, sub-district levels and in the health facilities.

2.2 Principles of Quality Assurance

There are five basic principles of quality assurance. These principles, as stated below, clearly show what QA is intended for.

1. Quality Assurance is oriented towards meeting the needs and expectations of our clients
2. Quality Assurance focuses on systems and processes
3. Quality Assurance uses data to analyze service delivery
4. Quality Assurance encourages the use of teams in problem solving and quality improvement
5. Quality Assurance uses effective communication to improve service delivery

Adapted from QAP

2.2.1 Meeting the Needs of Our Clients - Principle 1

The people we provide health services for are very important to us. Without them, we will not be in employment. Therefore we must do our best to satisfy them. In the past, we worked as if the clients did not matter so we did not involve them in healthcare, neither were their needs in service delivery addressed. With QA, the situation is now changing. All over the world, patients concerns regarding their rights to participate in healthcare delivery are becoming important. The clients are the main focus in quality assurance programmes.

There are two types of clients. These are internal and external clients. The external clients include people who directly use our services and those who have special interest in our services. They are made up of patients, relatives and friends and the community as well as other organizations: Non-Governmental Organisations (NGO's), District Assemblies, Ministries, Development partners (Donors) etc.

The internal clients are the workers in the health facility. Their needs must also be catered for so that they can provide quality care. We will discuss more about clients in chapter four. We can assess our client's needs either through surveys (interviews) or discussions with individuals and groups within the community who use our services. The clients are in the best position to say what constitutes quality to them. They tell us whether we are meeting their expectations through client surveys, community meetings, focus group discussions etc.

2.2.2 Focusing On Systems - Principle 2

Systems are the various aspects or components of service delivery that have to operate together as a unit in a facility to deliver quality health care. The three components of service delivery; namely; inputs, processes and outcomes have already been explained in section 1.5. When things go wrong with health services we often blame the staff. Whilst this may be true to some extent, in most cases, the problems lie in all the areas of service delivery.

In QA also, we address problems by looking at all the three areas - inputs, processes, and outcomes at the same time.

2.2.3 Use of Data to Improve Quality - Principle 3

We collect a lot of information (data) in our health facilities but we just send them on to the District Director without making use of them. Some of the data we collect include the number of people who attend the OPD, their age and sex. We also collect information on the number of cases of malaria, diarrhoea, mothers dying from pregnancy, delivery and after delivery.

These data are very useful. They can tell us where there are problems in service delivery. We can use the information in planning services and for monitoring. Data can also be used in identifying resources (people, drugs and supplies as well as the amount of money) required for health services.

We must analyze data and use it locally to improve services; some of these data can be shared with community members.

Sources of Data

There are different sources from which we get data, they include the health management information system, surveillance system and surveys.

a) Health Management Information System (HMIS): - This is the system set up to collect routine information from health facilities. This includes information from daily outpatient registers, child welfare clinics, admission and discharge registers.

b) Surveillance System: - The Public Health division also collects data on communicable and non-communicable diseases throughout the country. Some of the data collected are on Malaria, Diarrhoea, Acute Respiratory Infection, Immunization, Buruli ulcer, Tuberculosis, Guinea worm, Cerebrospinal meningitis

c) Surveys: - These are done periodically to obtain information that are not available in the routine data that are collected. The Ghana Demography Health Survey collects data every five years on fertility, mortality and morbidity.

Data Presentation

The data we collect can be analyzed and summarized and presented in simple forms that make them easier to understand. Some of the forms include Bar charts, Line graphs and Pie charts which are shown below.

A/ Example of a bar chart showing attendance at health facilities in Cape Coast district

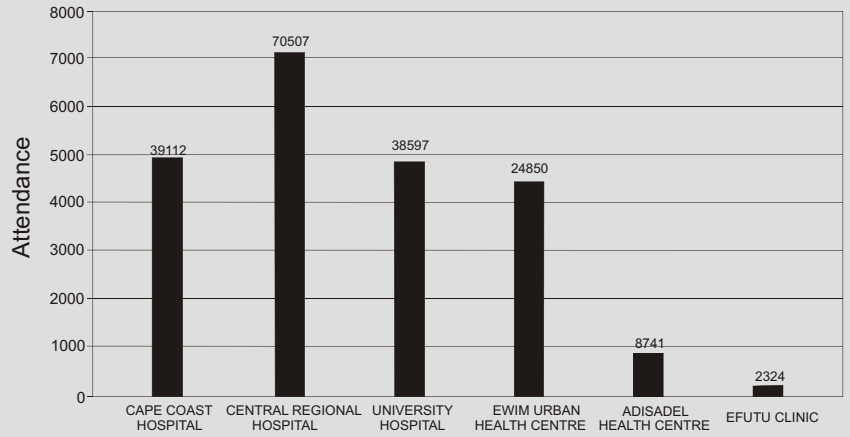


Fig. 3: OPD Attendance for Health Facilities in Cape Coast District. 2002

B/ Example of a Pie Chart showing OPD attendance of facilities in Cape Coast

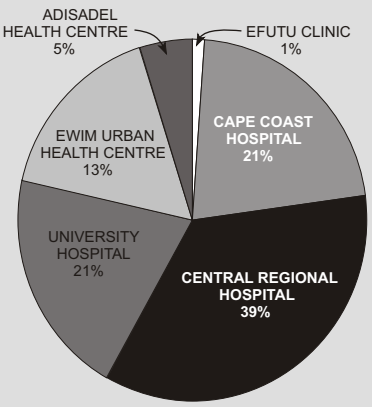


Fig. 4: OPD Attendance for Health Facilities in Cape Coast District. 2002

C/ Example of a line graph showing trends in maternal mortality rate over the years

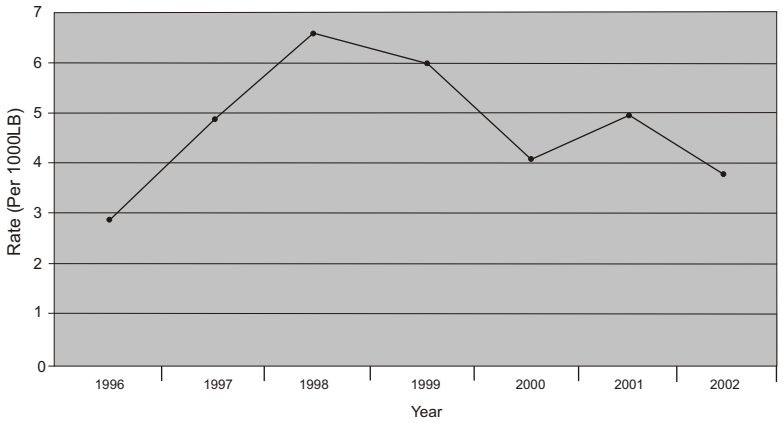


Fig. 5: Trend of MMR in Central Region. 1996 2002

When data is properly analyzed and the information obtained is very useful, it helps us to:

- ✍ See trends in service delivery e.g. if OPD attendances are decreasing or increasing;
- ✍ Know whether we have achieved our targets;
- ✍ Know where there are problems in service delivery.

2.2.4 Improving Quality Through Team Work - Principle-4

A team is a group of people who work together to achieve a common goal. In health service delivery we have different kinds of health workers working together. Let's use the outpatient services as an example of teamwork. There are labourers to clean the unit, records officers to register the patient, nurses to take the temperature and weight, the medical assistants to examine and prescribe the drugs, laboratory technicians to do the investigations and the dispensary technicians to give the drugs. All these people are playing important roles and if they work well in the team, the outcome is always good

Quality assurance uses teams in problem solving and quality improvement. A team can do a thorough analysis of problems, determine the best solution(s) and develop plans and implement them. In starting and sustaining quality assurance programme we need strong leadership support and commitment.

Advantages of teamwork

1. Knowledge and experiences of different people are shared
2. Various ideas are generated
3. Best option is selected
4. Ownership is generated
5. Responsibilities are shared

2.2.5 Effective Communication - Principle 5

Communication is a process by which messages are passed from a sender to a receiver with feedback to the sender. In health delivery there is communication between:

- Health worker and Patient;
- Health worker and Community;
- Health worker and Health worker.

a) Health worker and Patient

Good communication between health worker and the patient increases compliance to treatment and contributes to client satisfaction.

b) Health worker and Community

Health workers should have regular interactions with their communities to share information on service delivery and their role in healthcare. We need special skills to be able to effectively communicate with our communities

c) Health worker and health worker:

There should be good communication between health workers to ensure effective dissemination of information, understanding among staff and effective teamwork.

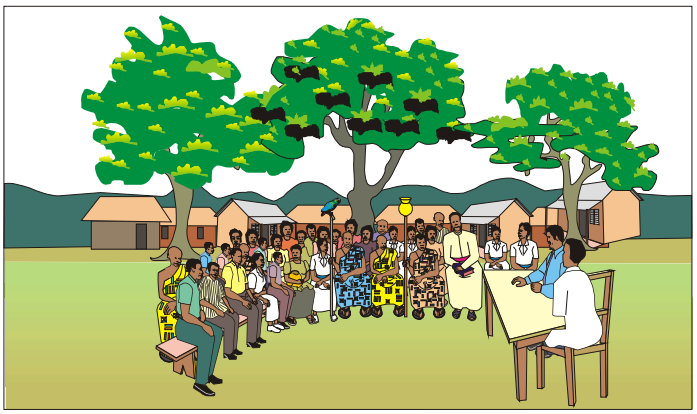


Fig. 6 : Interaction among health workers and Community

2.3 Benefits of Quality Assurance

Quality assurance is beneficial to everybody - the client, community, health workers, health managers and the health institution. Benefits of quality assurance are varied in nature. We have benefits to the clients, to the health worker and to the health institution.

2.3.1 Benefits to the Clients

Some of the benefits of quality assurance to the clients are:

- Good health outcomes.
- Client satisfaction.

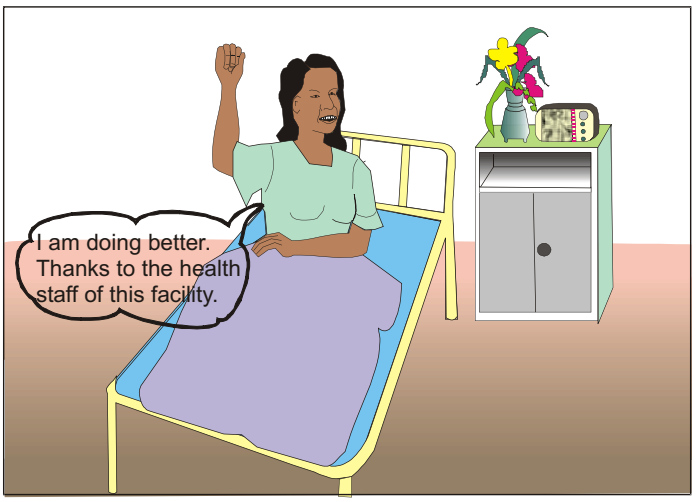


Fig. 7: A happy Patient

- Value for money.
- Less frustration.

2.3.2 *Benefits to Health Providers*

Health providers also benefit from quality assurance in the following ways.

- Health staff become more satisfied with their work.
- Health workers understand patients better.
- Information flow among staff is improved.
- Health staff who perform well are rewarded.

Fig. 8: A smart Nurse, showing satisfaction with her work.

2.3.3 *Benefits to the Health Institution*

Quality assurance brings some benefits to the health facility and they include:

- Patients become more satisfied with the services.
- More patients may use our services.
- The environment will become clean and beautiful.
- The facility will have a good reputation.

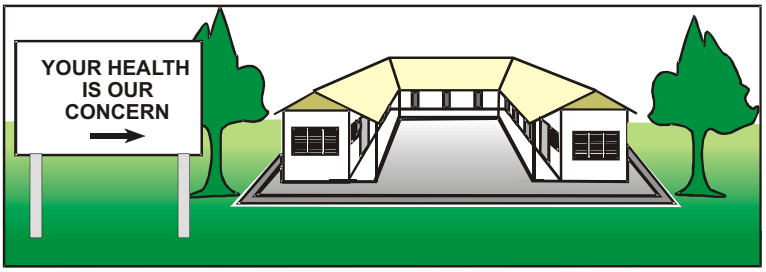


Fig. 9: A beautiful compound of a health facility

Fig. 10: Receiving an award for best Health Facility.

2.4 Cost of Poor Quality

Some health staff have the impression that quality is expensive. The usual complaints among health staff are poor salary conditions, inadequate funding, inadequate drugs and supplies including equipment. On the other hand, if we analyze what goes into service delivery in a facility we shall find out that poor quality care rather involves high wastage and is therefore more expensive.

The cost of poor quality includes all the costs that would not have been incurred if the right things had been done the first time. It also includes costs that result from having to provide the same service again and again.

Poor quality results in costs that we can readily see and costs that are hidden. Only a small part of the cost of poor quality is obvious to us. The major part is hidden costs. It can be likened to a hippopotamus in water; only a small part of its body is seen above the water, the bulk of the body is below the water and therefore hidden.

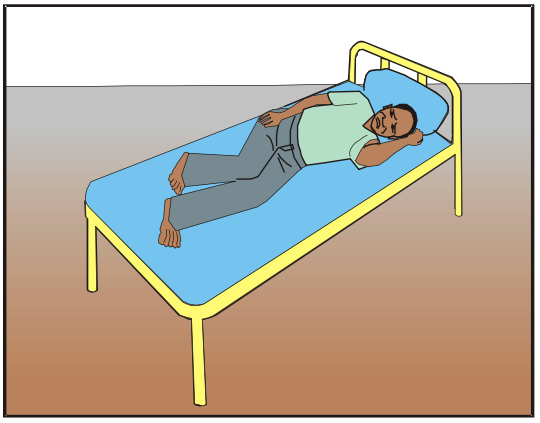


Fig. 11: A very sick patient

Costs of poor quality that are obvious to us include:

- Wrong diagnosis;
- Wrong treatment;
- Repeated visits to the OPD;
- Prolonged illness;
- Death.

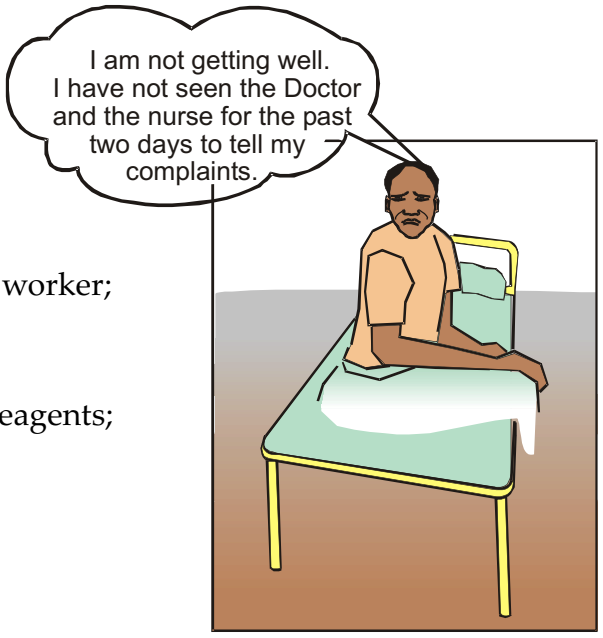


Fig. 12: A dissatisfied patient

Costs that are hidden include:

- Wasted time to both patient and health worker;
- Unnecessary treatment, wasted drugs;
- Patients not complying to treatment;
- Unnecessary laboratory tests, wasted reagents;
- Frustrated patients;
- Low staff morale.

Chapter Summary

In this chapter we have learnt that quality assurance involves setting of standards, monitoring and addressing problems. This should be done on a continuous basis in a planned and systematic manner.

Quality assurance can be practiced in the highly equipped hospitals and can also be practiced in the rural clinic with few staff and scanty resources.

We have also discussed the principles on which quality assurance is built.

We have also looked at some benefits and costs of poor quality.

Exercise

List five hidden costs of poor quality which have not been mentioned.

3

ORGANIZATIONAL LEVELS OF QUALITY ASSURANCE

3.0 Introduction

In the previous chapter, we learnt about what we mean by QA, the benefits and the cost of poor quality. We will now discuss the type of organization that is needed to implement quality assurance effectively. We need to stress the point that to implement quality assurance successfully, there should be appropriate structures at all levels. The roles, responsibilities and linkages of the structures within the organization must be clearly defined. These help to identify the monitoring and supervisory systems that are required to support the quality assurance programme. Again, it is important to note that, effective leadership and management commitment at all levels is key to the sustainability and success of Quality Assurance.

At the end of this chapter, you should be able to:

- Define your roles and responsibilities in quality assurance.
- Explain how your level links up with other levels.

3.1 National Level

Quality Assurance is not another vertical programme. It is an integral part of service delivery and applies to preventive, curative, rehabilitative and support services at all levels. It must involve every department and every health worker. Quality Assurance structures at all levels should derive from existing structures for effective implementation.

Support from the national level is crucial to the success of the quality assurance programme. The role of national level is to give direction and support to regions in the implementation of quality assurance.

This can be achieved through a national QA team or the establishment of a quality assurance unit. This team or unit will serve the following functions:

- developing policies and strategies;
- co-ordinating countrywide quality assurance program;
- developing clinical guidelines and protocols;
- setting national standards ;
- monitoring quality of care;
- comparing and ranking performance of facilities
- providing technical support to regional QA teams;
- mobilizing resources for quality assurance.

3.2 Regional Level

The regions have an important role to play in supporting the districts through facilitation, coaching, monitoring and supervision.

This is achieved through the regional QA team by:

- co-ordination, guidance and coaching;
- organising quality assurance workshops and seminars;
- training and facilitation during workshops;
- monitoring and supportive supervision to health facilities;
- encouraging high performance by comparing institutions and promoting best practice;
- developing region-specific standards and adapt national standards
- giving feedback to districts;
- establishing reward/incentive systems.

3.3 District Level

This is also a very important level that serves to co-ordinate and support health facilities in the district.

This is achieved through:

- co-ordination and guidance to the facilities;
- promoting QA awareness;
- monitoring performance of facilities;
- supporting the training of facilities in quality assurance;
- encouraging high performance by comparing institutions and promoting best practice.
- organizing training for healthworkers to improve their knowledge and skills

The team should provide feedback to health facilities - hospitals, health centres and clinics.

3.4 Facility Level

3.4.1 The Quality Assurance Team

At the facility level it is vital that a quality assurance team, made up of different categories of health workers, is formed to be responsible for co-ordinating the implementation of quality assurance. The team is likely to function better if management shows interest in the activities of quality assurance.

The Quality Assurance team is responsible for:

- co-ordinating and providing guidance and information to heads of department and facility management teams;
- promoting QA awareness;
- conducting patient satisfaction surveys;
- using facility data to improve quality of care;
- identifying quality problems and drawing up action plans;
- monitoring the implementation of quality activities;
- producing/adapting/updating relevant local standards, guidelines and protocols;
- disseminating information on quality assurance to staff.

Example

Hospital QA team Upper-West Region

In the Upper West region the QA team comprises:

- Medical superintendent
- Nurse Manager
- All unit heads
- Quality assurance co-ordinator

Example

Hospital QA team-Eastern Region

In the Eastern region the QA team comprises:

- Medical superintendent
- Hospital matron
- Biostatistician
- Pharmacist
- Laboratory technician

3.4.2 The QA Coordinator

The QA coordinator of a health facility is responsible for coordinating the activities of the QA team or committee. He is the link person between the QA team and Management.

3.4.3 The Role of Management in QA

The management team of the health facility should be committed to quality assurance. They should provide all the support needed to carry out quality assurance activities. Management should willingly commit the necessary resources to quality assurance.

3.4.4 The Role of Staff in QA

All staff should be aware of the need to improve quality in their routine duties. They should also bring to the attention of the QA team quality issues that are beyond them that require more analysis and planning. Members of staff assigned to carry out specific quality improvement tasks should see those tasks as part of their routine responsibilities rather than extra duties.

Units within a health center may be regarded as quality action teams, which identify and solve problems that emerge at the unit level, with every worker in the unit being part of the action team. As action teams, the units should refer problems that they cannot solve to management or the health facility QA team. For instance, a problem that requires the acquisition of material inputs to solve may be referred to management. On the other hand, a problem that requires more detailed analysis may be referred to the QA team.

Chapter Summary

This chapter discussed organization and structures at all levels for QA implementation. It emphasized that QA should not be seen as a vertical programme, but should be applied to all aspects of health care - promotive, preventive, curative, rehabilitative.

The organization at the National, Regional, District and facility levels have been discussed. Commitment on the part of managers is crucial to a successful QA programme.

General guidelines have been given for a team approach to QA at all the levels.

Exercise: (Group Work)

Compare the composition of the QA teams for the Upper West and Eastern Regions of Ghana as indicated on page 23 and answer the questions below.

1. Which of the two teams is better composed? Give reasons to support your answer.
2. What differences exist in the two teams in terms of membership.
3. Suggest an alternative to the two teams discussed and give reasons why your composition is the best.

4

RELATIONSHIP WITH OUR CLIENTS

4.0 Introduction

In the previous, chapter we discussed the type of organization that we need to put in place at the various levels for health facilities in the Ghana Health Service (GHS) to implement QA.

We have this saying in the business world that "the customer is always right". This means that customers have a choice as to what they want and therefore will continue to use products and services as long as they are convinced of the quality.

Just like the business sector, the health sector can also make use of the terms *suppliers* and *customers* or *clients.* We shall use the terms *customer* and *client* interchangeably in this chapter

By the end of this chapter, you should be able to:

- Explain the terms *supplier, internal client* and *external client.*
- State what your internal and external clients expect from you
- Discuss the roles of external client.

4.1. Who Is A Supplier?

As health workers, we are all involved in the supply of one form of health service or the other. Medical Assistants, nurses, records officers, midwives, dispensary technicians, and labourers are supplying various services. All these staff contribute to provide quality services to the client.

4.2. Who Is A Client?

A client is the one who uses our services. There are two types of clients of a health care facility: *internal clients* and *external clients.*

4.2.1 The Internal Client.

As health staff, we also become internal clients when we receive services from other health staff at one time or the other. The expectations of the internal clients must therefore be met. For instance, the Medical Assistant (MA) depends on the laboratory staff to make accurate diagnosis. In this relationship, the Medical Assistant is the client of the laboratory technician. Since the ability of a Medical Assistant to make accurate diagnosis depends on the laboratory technician, he expects a certain standard of practice from the technician.

Fig. 13: A Nurse expressing satisfaction with the service of a Dispensary Staff .

In the same way a nurse who collects patients' drugs from the dispensary becomes a client to the dispensary technician. The nurse therefore expects the dispensary technician to provide services that will meet her expectations.

There is the need for a good relationship between the staff providing service (supplier) and the internal client if quality of care is to be achieved.

All health workers should therefore be involved in the QA programme.

4.2.2 The External Client

The external clients are the patients, relatives of patients and anybody who seeks the services from the facility. External clients have their own expectations about quality health services. They continue to use our services so long as they are satisfied.

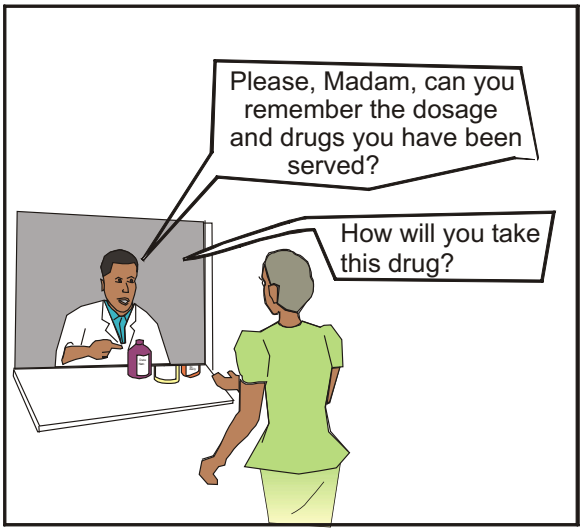


Fig. 14: A patient receiving drugs from the dispensary

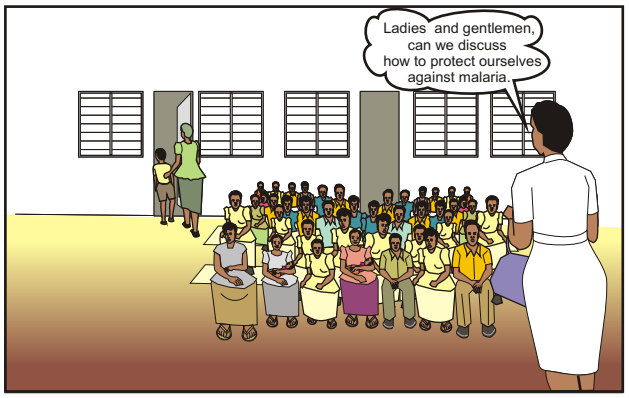


Fig. 15: Patients listening attentively to a health talk at the OPD.

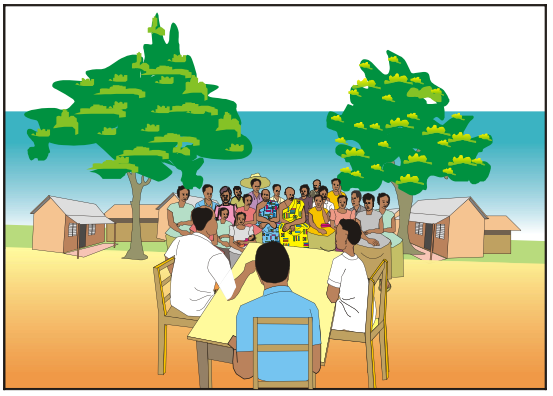


Fig. 16: Health workers-community interaction

Table 4.1 Internal Client Expectations

Service supplier	Internal client	Client Expectations
Records officer	Medical assistant	- Prompt attention to patients - Accurate recording - Good storage and retrieval of records
Dispensary Technician	Nurse	- Prompt attention - Respect and friendliness - Readable writing - Correct dosages

Table 4.1 External Client Expectations

Service Supplier	External Client	Client Expectations
Nurse	Patient	- Prompt attention - Respect and dignity - Friendliness - Privacy - Confidentiality
Record Officer	Patient	- Prompt attention - Respect - Friendliness - Confidentiality of personal record

The two tables above (Table 4.1 and 4.2) show the expectations of internal and external clients.

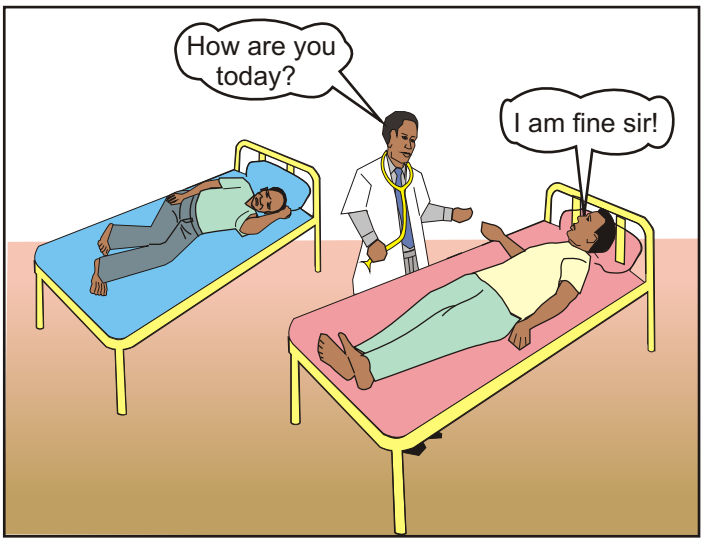


Fig. 17: A nurse attending to a patient

4.3 The Role of Client in QA

It is important to recognise the roles that external clients can play in the provision of quality service to them. The key roles of clients in QA include the following:

- ***Definers of quality***
  Clients are in the best position to tell us their expectations and what quality means to them.

- ***Evaluators of quality***
  We can call on our clients to assist us in assessing quality through periodic satisfaction surveys, client complaints and staff-client durbars.

- ***Co-producers of quality***
  Our external clients must not only be seen as users of service but also as partners who are helping us to provide quality health care for them

- ***Informants on quality***
  They provide information on what they experience during the process of care and what the results of care are.

- ***Contributors to Quality Practice***
  When clients are educated or informed on health matters they can contribute to decision making in our facilities. If they are involved in the management of the facility, their decisions can help in changing or controlling the behaviour of our staff.

✍ *Reformers of health services*

Through the above contributions, clients play important role in promoting changes in our health care delivery.

Chapter Summary

This chapter has reminded us that those who use health services are our external clients whilst those we work within the health sector are our internal clients.

Our external clients play different key roles in improving quality. We need to build stronger relationships with them so as to provide better quality service

Exercise

If you were a patient what would you expect from the health staff? List as many as you can.

5

STANDARDS

5.0. Introduction

In the last chapter we discussed the need to build good relationship with our clients to improve quality. We will now look at standards, which provide the basis for measuring the level of quality that is required.

At the end of this chapter, you should be able to:

- Define standards
- List the various types of standards used in health facilities
- Use standards to improve quality

5.1 What Is A Standard?

The term standard is used very often but its meaning is not understood by most people. A Standard is a statement of expected level of quality. It states clearly the inputs required to deliver a service, how things should be done (process) and what the output or outcome should be. When we compare what is expected in the standards to what we do, we shall be able to identify any quality gaps and then make plans to improve upon it.

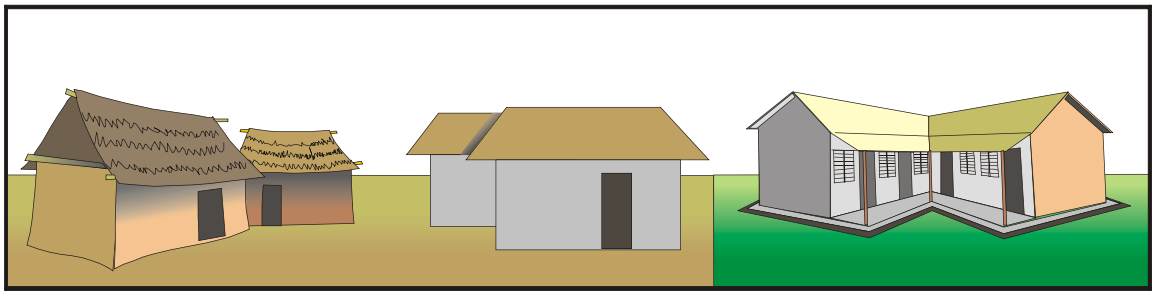


Fig. 18: Quality Gap between present and expected Standard

Standards can be set for any level of the healthcare system i.e. national, regional, district, sub-district. They can be developed for use in public health, clinical care and support services.

There are also international standards e.g. those developed by the World Health Organization that can be adapted to that of the country.

5.2 Types of Standards

In carrying out any health activity there are three stages that are followed. We need inputs (resources), we should also define clearly how things are going to be done (processes) and know what results to expect (outcome). Standards must therefore be set for each of the three areas.

5.2.1 Input Standards

Input or structure standards define the resources that must be supplied for the activities to be carried out e.g., the physical structure, people, equipment and materials. For example to provide outpatient services we need a building with a number of rooms for consultation, treatment, laboratory etc. We also need trained nurses, medical assistants or doctors and equipment like thermometers, weighing scales, sphygmomanometers

5.2.2 Process Standards

Process standards describe the tasks or steps that must be carried out until the activity is completed. In the example of outpatient services, the steps include, registration, recording of temperature and weight, consultation and collection of drugs

5.2.3 Output/ Outcome Standards

Output/ Outcome standards describe the outputs or results of the activities carried out. For example - the number of patients seen at the OPD.

There are a number of standards that have been developed by the Ghana Health Service and some of us have been trained in their use. A few examples are:

- Integrated Management of Childhood Illness (IMCI) case management guidelines
- Malaria case management guidelines
- Tuberculosis case management guidelines
- Reproductive health policy and standards and guidelines

5.3 Uses of Standards

The use of standards will ensure quality care and reduce the differences in managing patients among prescribers. It will also get value for money.

Standards are used to:

- Define quality
- Determine, inputs, processes and outcomes, and
- Develop indicators to monitor quality.

Let's examine an example of standards for antenatal care using the three (3) areas namely, input, process and outcome as illustration

Input standards

These are measured in terms of quality of physical structure, equipment, supplies and staff.

Physical structure

The antenatal clinic should have a reception and waiting area with adequate seating for women. A separate examination room for history and examination

Equipment and supplies	***Staff***
Standing scale with Height measure	Qualified nurse midwife(s)
Sphygmomanometer	Support staff
Maternal health records	
Fetoscope	
Dipstick for urinalysis	
Measuring tape	
Examination table	
Immunization equipments	
Laboratory for basic tests	
Drugs- Folic acid, Iron, anti-malarials	

Process standards

These are written out in the:

- National Reproductive Health Policy, Standards and Protocols
- Laboratory standard operating procedures; and
- Medical records procedures.

Output/ Outcome standards

- Pregnant women will attend at least four times during pregnancy.
- Ninety percent (90%) of women attending antenatal clinic will report satisfaction with care given (client survey).

5.4 How Do Staff Get To Know About Standards?

When standards have been developed, staff should be made aware of them so that they can be used to improve quality of care. There are several methods that can be used depending on what has been developed. They include:

- Training of health workers (in service and on the job training)
- Launching of the standard
- Seminars/ conferences
- Developing job aids
- Support supervision.

When standards have been well communicated, the health worker knows the standards, he/she accepts them and changes his or her practice accordingly.

Chapter Summary

Standards define what level of quality we should be expecting.

It states the inputs required to deliver a service, how things should be done (processes) and what the outcome should be.

Standards enable us develop indicators so that the level of quality can be measured and monitored.

We have also discussed the types and uses of standards

Exercise

Mention 5 standards you are aware of which have not been mentioned.

6

MONITORING AND SUPERVISION

6.0 Introduction

In the previous chapter, we discussed standards and how they are used to improve on the quality of services

By the end of this chapter, you should be able to:

- Explain what is meant by monitoring in Quality Assurance;
- Explain the importance of monitoring in Quality Assurance;
- Describe some methods used for monitoring quality; and
- Describe how to conduct patients' satisfaction survey.

6.1. What Is Monitoring?

In order to assess whether we are making any improvement in quality of service delivery, we need to do regular monitoring. It is important for us to understand what is meant by the term 'monitoring'.

> Monitoring is the **collection, analysis and interpretation of data in order to assess whether we are making any progress towards achieving our set targets or improving quality.**

Data for monitoring quality may be from the routine data that we collect in the facilities and in the communities, for example OPD attendance and immunization coverage.

It may also be data that is collected from time to time to follow our performance on selected indicators, for example patient waiting time, drug availability.

Another aspect of quality monitoring is to check if we are keeping to standards, protocols or guidelines. For example a health centre may compare the treatment of Malaria with agreed standards of treatment.

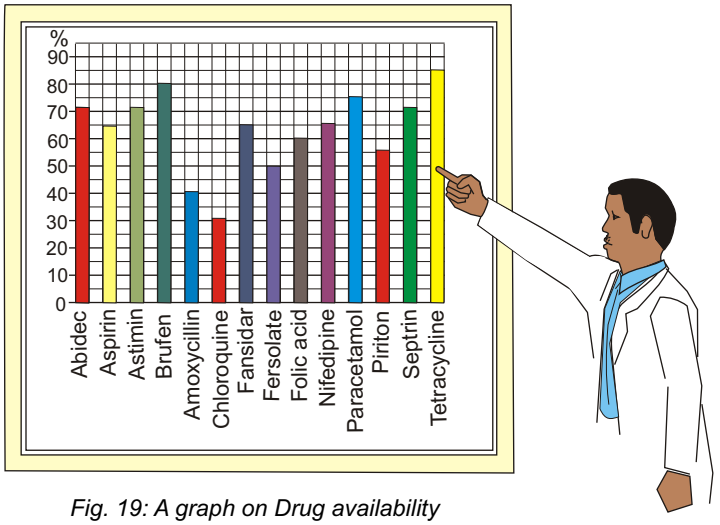


Fig. 19: A graph on Drug availability

What is the Importance of Monitoring Quality of Care?

- Monitoring helps us to identify gaps in quality of our health care delivery.
- It provides lessons to learn from as we progress with our implementation.
- It tells us if we are making progress in improving quality of care.

Monitoring therefore helps us to identify problems with the implementation of our plans so as to take the necessary steps in order to achieve our targets.

6.2 Methods for Monitoring Quality of Care

There are many methods of monitoring quality. The common ones include:

- Review of routine health information. For example, Health Management Information System data on OPD attendance, In-patient admissions and deaths, Immunisation coverage.
- Client satisfaction surveys.
- Patients complaints system.
- Critical incidents -Adverse events.
- Mystery clients
- Supervision

We shall now discuss each of these quality-monitoring methods.

6.3 Client Satisfaction Survey

This is a good way of getting the clients' views on our services.

- It tells us what the client's expect from our health services.
- By telling us their expectations and making suggestions, clients are indirectly participating in the decision making process of the facility.
- It promotes services that are sensitive to the needs of the client.

6.3.1 Preparation for the survey:

It is important to prepare very well before starting any client satisfaction survey. The quality assurance team should:

- Identify the objective of the survey. We need to be clear about what we want to achieve at the end of the survey. It is only when we get our objectives right that we can know the relevant data to collect.
- Develop your questionnaire. There is currently an existing questionnaire on satisfaction, which is widely used by health facilities (refer appendix 1A).
- You may have to translate the questionnaire into the local language. This should be done and agreed upon before the interviews are conducted.
- Determine the number of people to be interviewed (sample size). It is recommended that a minimum of 50 clients are interviewed in a clinic or health centre survey.
- Select and train the interviewers on how to conduct the interviews.
- The interviewers should not be known to the clients.

6.3.2 When do we collect the data?

Information should be collected from clients when they are about to leave the facility. This is called the EXIT interview.

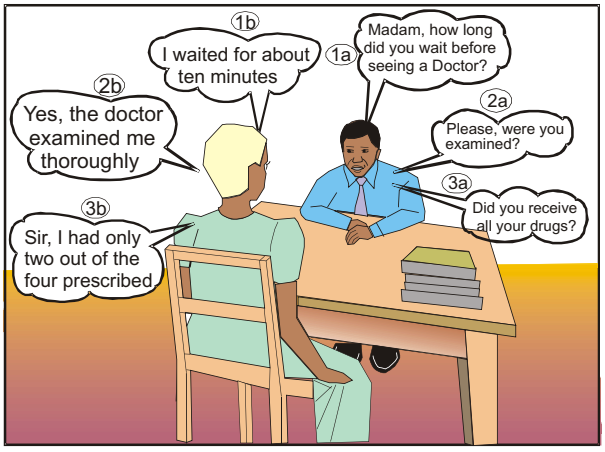


Fig. 20: Interviewer sitting with interviewee

6.3.3 How do we collect the data?

These are the measures that should be taken when conducting exit interviews.

- Spread data collection over two weeks or over a period of 10 days. (5 per day from Monday to Friday)
- Select patients randomly. You will have to decide whether you will select every 3rd person or 4th person or 5th person in that order.
- Number your questionnaires in consecutive order. (1,2,3,4,5)
- Before interviewing the client, introduce yourself and seek his consent.
- Explain briefly why you are carrying out the survey (to help improve on services for clients)
- Let the same person interview the clients to ensure that questions are asked the same way.
- The interviewer should not be in uniform.
- Do not influence the client's responses.

6.3.4 Data Analysis and Report Writing.

After gathering the information from the clients, you analyse and present your findings using a simple data entry form. For example assuming that 25 out of 50 clients interviewed said that they were seen in less than 1 hour then the % of Clients seen within 1 hour is: 25/50 x 100 =50%

The % obtained for all the indicators are displayed graphically for interpretation. Different ways of presenting data are discussed in Chapter 7. The formulae for calculating some patient defined indicators are shown in appendix 2

6.4 Clients Complaints System

This is another way clients can inform you about the services that are being provided without doing a survey. There are several complaints system but the most common and simple ones are:

1. The use of complaints/suggestions box.
2. The use of client complaints desk.

6.4.1 Complaints /Suggestions

A complaint box as the name suggests, involves placing a clearly labelled box at an open place e.g. the reception. Attached to the box is a pen and paper, which clients will use to write down their complaints and suggestions. There should be a person responsible for emptying the box, analyzing the complaints and reporting on findings regularly to management for action.

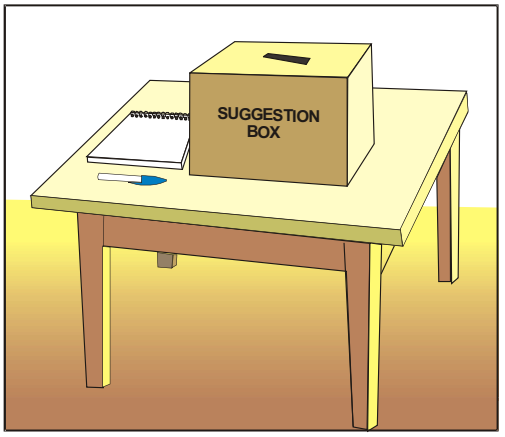


Fig. 21: The Suggestion Box

When using the complaint box, the following should be noted:

1. It should be possible to not identify those who make the complaints; else it would scare off clients or patients who would like to complain about the quality of services.
2. Prompt investigations should be carried out and feedback given to clients who provide their address.
3. Staff should not sit by the box.

There are some problems that relate to the use of the complaints box. Among them are the following:

1. The box may not be opened for very long periods.
2. People may write about things that are not related to the quality of service.
3. They may also use it to make accusations against health workers.
4. It is not useful in an area where a large number of the clients are illiterates.

6.4.2 Client Information and Complaints Desk

A client Information and Complaint Desk/Centre is normally located at a place that is accessible to clients.

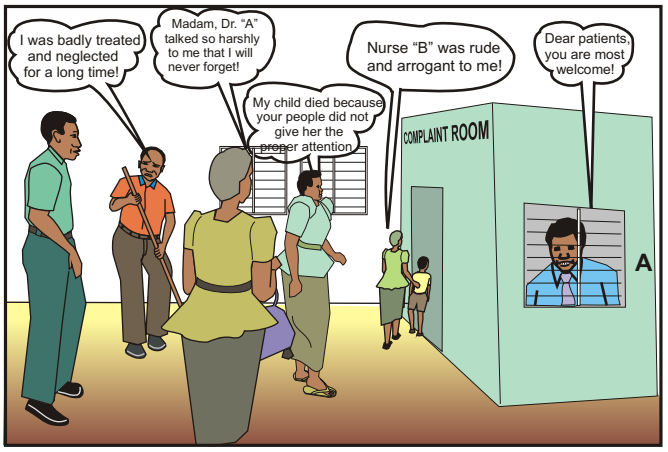


Fig. 22: At the Complaint desk.

A well-trained staff with good interpersonal skills should be in charge of the desk. She or he is responsible for giving the necessary information and direction to clients, listening to their complaints, documenting them and following up on complaints.

Most often complainants have the opportunity of receiving feedback on the spot. Some of the complaints may need further investigation. It is important that feed-back is given to the complainant after investigations have been conducted and where the facility is in the wrong, apology should be rendered.

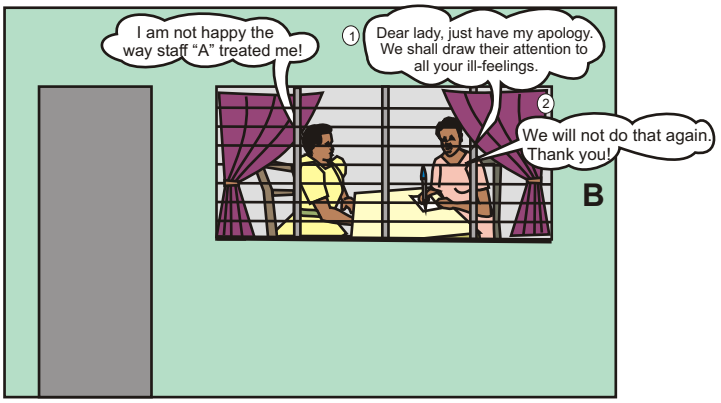


Fig. 23: A client receiving advice from a staff.

The records of the complaints should be reviewed regularly and feedback given to management and staff.

6.5 Records Review

This is the collection and analysis of information from existing records and reports. The routine data we collect from the Health Management Information System (HMIS) is an important source of information for monitoring quality.

We should take interest in analysing the data and use it to improve quality in our facilities. For example, analysing trends in immunization coverage can show us whether we are meeting our set target.

We can also review patient records to see if prescribers are complying with standards, protocols and guidelines.

6.6 Review of Adverse Incidences

Adverse incidences are unusual incidents that occur in the course of duty at the work place e.g. a person collapsing after an injection, adverse events following immunization.

Such an event should be well documented and thoroughly reviewed immediately after it has occurred with a view to putting in measures to prevent similar occurrences in the future. The process involves a systematic review of all records on the incident. If you are unable to undertake the review, you should consult your supervisor to support you do it.

6.7 Mystery Client

In this approach, the institution engages the services of an individual called the mystery client who visits the health facility and pretends to be receiving health care services in the facility. Without attracting attention, he or she observes, assesses and at times experiences the quality of services rendered by the staff to clients. The mystery client then reports his or her findings to the institution for analysis. The nature of the task of the mystery client requires that he or she must be confident, accurate and reliable. He or she must also have good memory in order to reproduce what was observed and experienced in an unbiased manner after the process.

6.8 Supervision

Supervision is a process of guiding, helping and teaching health workers at their workplace to perform better. It involves a two-way communication between the one supervising (supervisor) and the one being supervised (supervisee). Adequate preparation should be made in terms of planning and budgeting before the visits.

At the end of the visit, the supervisor should make time to discuss with staff their findings and agree on what actions to take to improve on performance. A report must be written by the supervisor and feedback sent to the staff.

There are various types of supervision and three are described below:

1. Facilitative Supervision: It is also called supportive supervision because the supervisor does not see himself as an inspector looking over the shoulders of his subordinates for faults. Instead, he sees himself as part of the quality team guiding the staff to identify their weaknesses and gaps in quality of service delivery. Together with the supervisee, they develop appropriate solutions to improve on their performance.
2. Inspectorate type: The supervision here focuses on finding faults and has minimal interaction. It therefore leaves little or no learning experience to the one being supervised.

3. Self- assessment or peer-based supervision: This is where the supervisor's role is indirect. It is the type of supervision where staff belonging to the same team or professional group sets up a system whereby they meet regularly to discuss their own performance with little or no external role.

Chapter Summary

Monitoring is the way to determine how much progress we are making towards achieving our set objectives.

In this chapter, we have come to understand that quality monitoring involves the collection, analysis and interpretation of data to know where we are in quality of our service delivery.

Data for monitoring quality may be obtained from routine HMIS data, reports or periodic data from surveys i.e. patient satisfaction surveys.

We have also discussed the various types of supervision.

We have also learnt about other methods for monitoring quality.

As we implement quality assurance, let us remember to use the data we collect to improve the quality of our services, which is one of the five principles of quality.

Exercise

What would you do as a health team when you receive persistent reports about an unprofessional conduct of :

a) The Officer in charge of the health facility.
b) The Nursing Officer
c) The Watchman.

Give reasons for your actions?.

7

TOOLS FOR MONITORING

7.0 Introduction

In the previous chapter, we explained the importance of quality monitoring and the methods that can be used to monitor quality. Some tools used by the various methods for data collection are discussed in this chapter.

At the end of this chapter you will be able to:

- explain the term 'Indicator' and its importance.
- list some of the indicators for monitoring quality at your level
- List and explain some tools for collecting data

7.1 Indicators

You need to use Indicators to make monitoring meaningful. An indicator can be defined simply as **the yardstick by which you measure progress.**

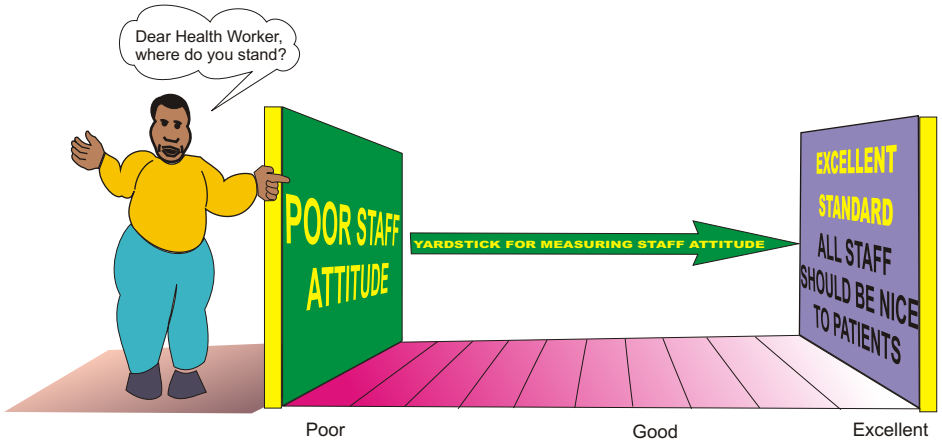


Fig. 24: Yardstick for measuring Staff attitude

Indicators are derived from standards. Depending on what you set out to do, you may select indicators that will help you measure them.

We can categorise Indicators for monitoring quality into Client and Professional perspectives. Client-defined indicators are those derived from the clients expectations and professional indicators are those derived from professional standards.

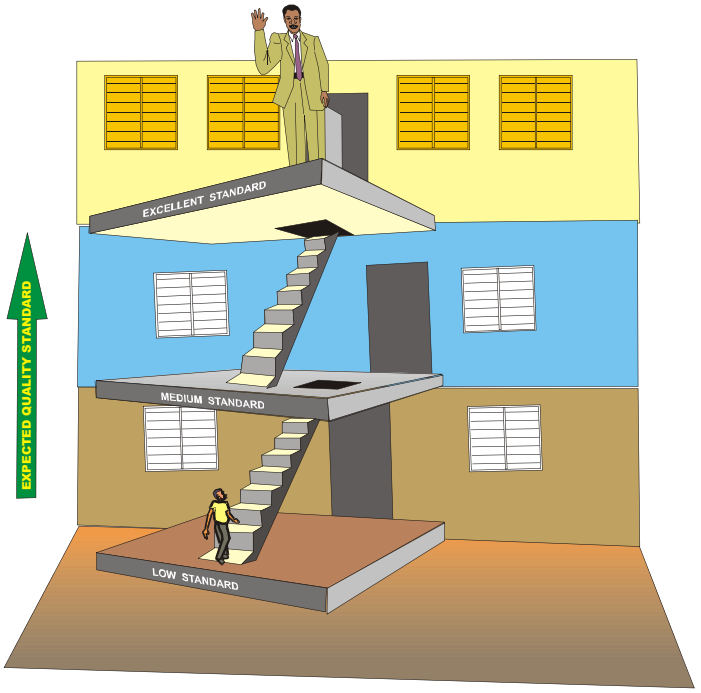


Fig. 25: Climbing the steps to achieve quality standard

Table 7.1:
Indicators for Monitoring Quality on Patient Satisfaction (OPD)

No.	INDICATORS
1.	Proportion of patients seen promptly
2.	Proportion of patients seen without an unnecessary delay
3.	Proportion of patients examined by the Doctor
4.	Proportion of patients told about the diagnosis
5.	Proportion of patients given instructions about how to take their treatment
6.	Proportion of patients told whether or not to return
7.	Proportion of patients having privacy during consultation
8.	Proportion of patients receiving all drugs prescribed
9.	Proportion of patients perceiving staff attitude to be very good
10.	Proportion of patients perceiving clinic to be clean
11.	Proportion of patients seeking emergency treatment in the past 6 months who were seen promptly
12.	Proportion of patients feeling very satisfied with their visit
13.	Proportion of thirty (30) essential drugs in stock.

The table above provides a set of indicators widely used in health facilities in the Ghana Health Service to monitor quality from the clients' perspective.

Examples of routine indicators:

- Number of OPD attendance
- Percentage of children under 1 year who have completed their Immunization coverage
- Number of injection abscess
- Percentage drug availability
- Number of supervised deliveries
- Number of drugs prescribed for a patient

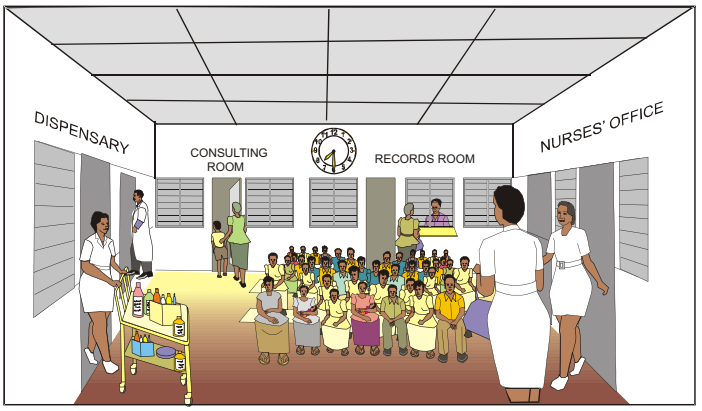


Fig. 26: A scene at the OPD

In addition to the above, the QA team can also use indicators that look at how we manage patients. We have standard guidelines for the management of diseases like Malaria and Diarrhoea in children under 5 years.

Indicators that have been developed from these guidelines include:

- Proportion of children weighed at OPD
- Proportion of children whose temperatures were taken
- Proportion of children who were diagnosed as having Malaria and prescribed oral chloroquine or artesunate-amodiaquine.
- Proportion of children who were diagnosed as having diarrhoea and given ORS.

7.2 Tools for Collecting Data and Use of Information

Before you set out to collect data for monitoring the progress of your QA, you need to agree on how you are going to collect the data.

The common tools used for data collection during monitoring are:

- Checklist
- Observational guide
- Questionnaires
- A combination of all the 3.

7.2.1 Checklist

Checklist contains the important information you will need to collect to assist you monitor quality in your facility. It lists out the important points that should guide you to ask the necessary questions and make the required observations. A sample checklist can be found at appendix 1B.

7.2.2 Observational Guide

It is a list of key points that will guide you to observe the important activities that you need to take note of.

We can use this method to assess staff attitude at the OPD by observing how patients are handled by health staff at the various points during OPD consultation.

We can also use observational guide to assess how sick children are managed at the OPD by sitting in the consulting room and quietly observing the process of consultation using for instance, a sample observation guide at appendix 1C. The rating scale provided with the guide gives the result of observation a numerical value.

7.2.3 Questionnaire

A questionnaire is a useful tool containing questions on key issues that you want to know about. There are several types of questionnaires. A few of them are stated below:

- ***Structured questionnaire:*** This provides possible answers for the one being interviewed to choose from.
- ***Open-ended questionnaire*****:** The one being interviewed is encouraged to come out with his or her own answers.
- ***Semi-structured questionnaire*****:** This combines both structured and open-ended.

7.3 Dissemination of Information on Quality Assurance

The importance of gathering information about quality is to improve our services. People are more likely to use the information when they understand it, hence the need for creative ways to disseminate it. It is important to discuss your findings first with management before presenting them to the general staff body and the community.

Find below some guidelines for dissemination:

- Findings from monitoring should be presented in a very clear manner so that staff can easily understand.
- Findings should be presented as absolute figures; proportions or percentages; pictorial form e.g. line graph, bar chart, pie chart and histograms.
- Always remember that after initial discussion of your findings with management, you would have to follow it up with a written report so that they can take action where necessary.
- Findings should be displayed on staff notice boards.
- Always remember to hold staff durbars to inform them about your findings.
- The findings and the proposed solutions should be shared with clients and the community. The use of audiovisual equipments like the video will make your message clearer.

Below is an example of bar charts displaying quality indicators

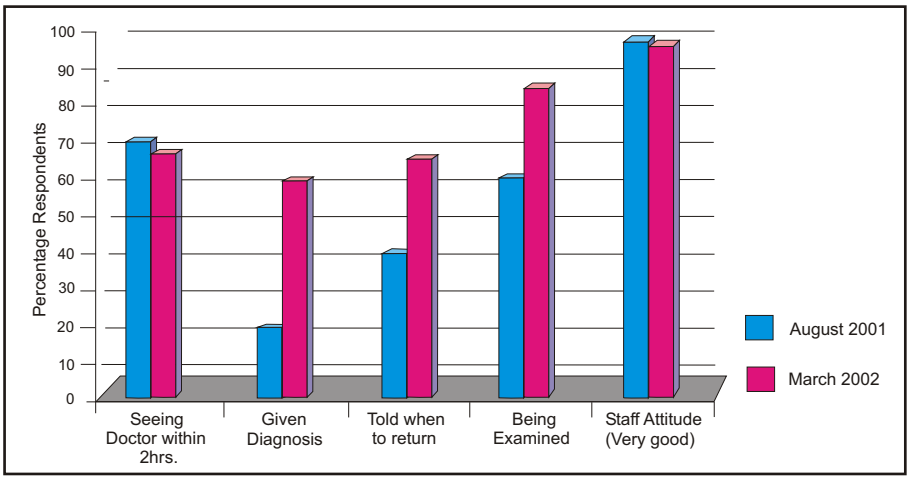


Fig 27: Example from QA Monitoring

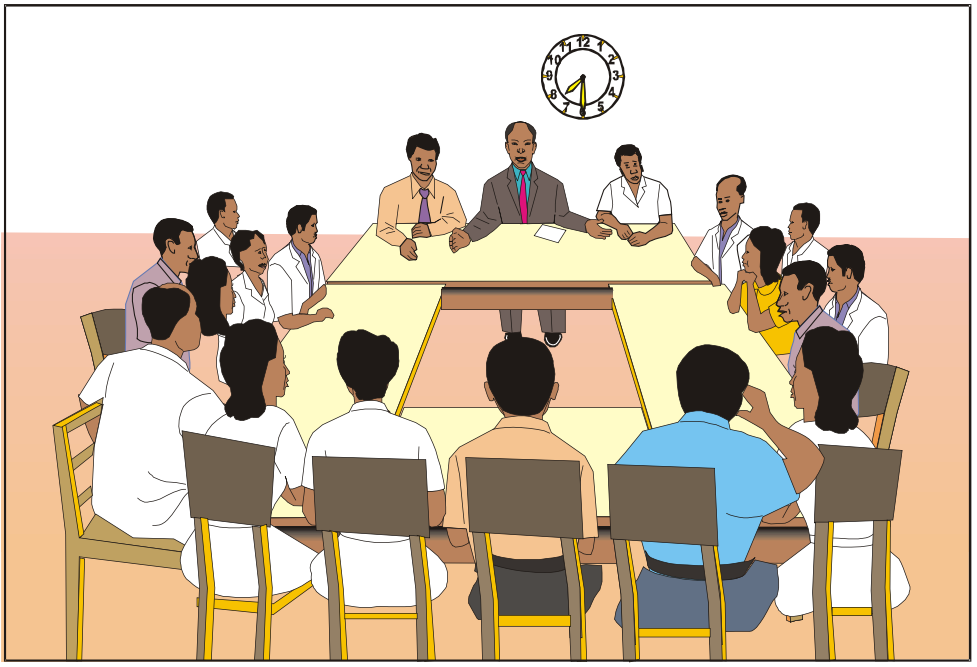


Fig. 28: Discussions about the performance of the facility.

Chapter Summary

In this chapter, we have looked at Indicators as tools for monitoring quality. We have also looked at the various tools for collecting data for quality monitoring. For example we have discussed questionnaires, which are useful tools for patient satisfaction survey.

We should remember that as we monitor our indicators over agreed periods, we will be following trends of our performance.

The various types of supervision that are usually carried out to ensure effective implementation of quality assurance activities have also been discussed.

Exercise

Assuming that the data below represents findings from your client satisfaction survey,

1. Draw bar charts of percentage respondents against the various key issues.
2. Comment on the bar charts you have drawn?

KEY ISSUE	% of respondents per quarter			
	1st quarter	2nd quarter	3rd quarter	4th quarter
The OPD is not clean	75	50	40	35
I was not told how to use my drugs	50	20	15	0
Nurses at the OPD are very rude to patients	65	40	35	20
I was not told when to come back	30	30	15	5
I wasted too much time before seeing a Doctor	75	60	45	25
I was not given receipts for the drugs I was supplied with	45	40	25	0
The Doctors come to work too late	85	85	70	50

8

QUALITY IMPROVEMENT

8.0 Introduction

In the previous chapter, we discussed quality monitoring. Having come this far, we shall now learn how to use this information to improve the quality of our services. The importance of any QA program is to measure what we achieve in service delivery against what is expected of us. This tells us of the quality gap that we need to improve upon.

By the end of this chapter, you should be able to:

- Explain the Quality Assurance (QA) Cycle
- Describe the key steps in quality improvement
- Develop Action Plan for implementation.

8.1 Quality Assurance Cycle

The QA cycle is a guide that can be followed to continuously improve quality of our health services. It has different stages and by going through them, the QA team can follow the cycle to *assess, monitor* and *improve* the quality of care we give to the clients. You can start from any stage of the cycle but have to complete it once you start. Just be simple, practical and creative in your approach.

8.2 Steps in the quality assurance cycle

What then are the main steps in the QA Cycle and how can they be used to improve quality? As can be seen in figure 30 below, there are ten main steps in the QA cycle; these are explained below from subunit 8.2.1 through to 8.2.10.You will notice that success in the use of the steps at your workplace depends on team work and effective communication among the staff.

8.2.1 Plan for Quality

We do planning in our everyday lives and in our facilities also. It is equally important to plan for QA. Planning for quality is not an individual task but should be done by the whole QA team. It is the task of this team to carefully plan activities that will facilitate the implementation of QA activities in your facility. A budget should be prepared with the plans so that resources are committed for quality assurance. The activities should be well organized, systematically carried out and properly coordinated.

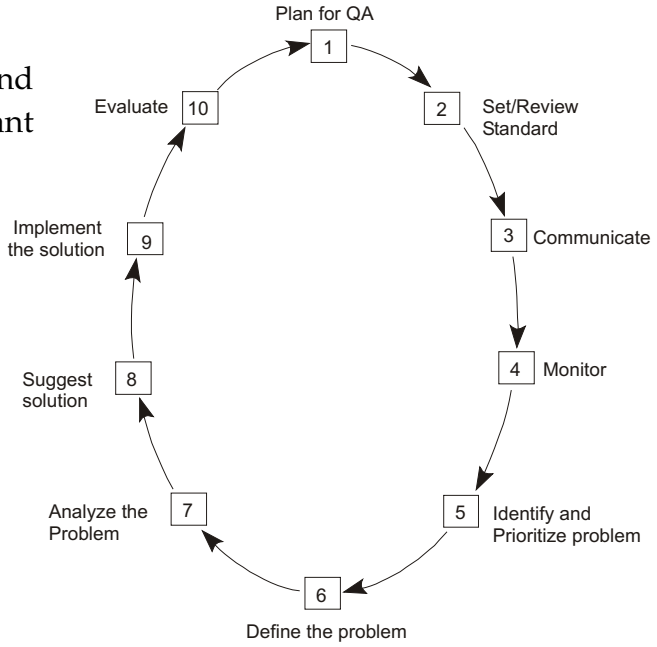


Fig. 29: Quality Assurance Cycle

8.2.2 Review Standards

We need standards to check whether our activities meet client and professional expectations. Standards are usually set at the national level but can be adapted for the lower levels. Protocols and Guidelines can also help us to improve the quality of our services. *Make a list of some of the guidelines and protocols available at your facility.*

8.2.3 Communicate Standards

Communication plays a very important role in QA. Whatever decision the team takes must be well understood by all members and properly communicated to other staff. It is important to communicate these standards set by the facility to all members of staff. For example all prescribers in the facility should know about existing guidelines and protocols and comply accordingly. Each facility has its own effective way to communicate information to the staff. Examples include meetings and durbars. *What other examples do you have?*

8.2.4 Monitor the Use of Standards

Once we have our standards, protocols and guidelines in place, we then monitor to see whether we are adhering to them or not. For example, we can always check to see whether the temperature is taken and recorded for malaria cases. The main aim of monitoring is to check whether or not we are complying with standards.

8.2.5 Identify and Prioritize Problems

In our facilities, some of the problem areas are related to patient satisfaction, poor prescription habits, infection control practices etc. Since we cannot solve all the problems at the same time, there will be the need to prioritize. We can determine the

priority problem areas as well as opportunities for improvement. It may be helpful to first select the simple ones that we have resources to solve. Once we see results of our activities, we are encouraged to do more.

8.2.6 Define the Problem

Once the problem areas have been identified, we try to define them. We state them as problems. What does this mean? Consider the following two statements about the state of the clinic compound:

- *The compound is dirty because patients litter the place and the few laborers are lazy*
- *45% of patients complain the compound is very dirty.*

In the above example the actual problem is the very dirty compound. The size of the problem is that 45% of patients complain about it.

A good problem statement does not assign reason or blames people. The second statement obviously better defines the problem.

8.2.7 Analyze the Problem

Every problem has got its underlying causes. We therefore analyze to find the root causes to the problem. Simple methods for problem analysis include Brainstorming, But Why and Tree diagram.

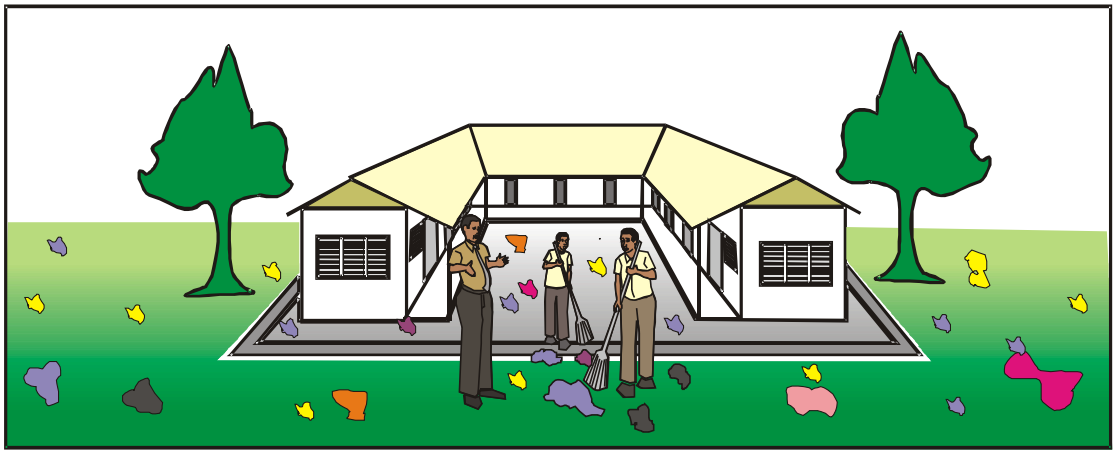


Fig. 30a: Why is the compound dirty? But why?

Example of 'But Why' analysis

The clinic is very dirty

But Why?

People litter the compound.

But Why?

No Dustbins

The root cause of the problem in this case is the absence of dustbins. The situation may differ in your work place. There is therefore the need to carefully analyze the problem in order to get to the root cause.

In brainstorming, the QA team freely talks about the problem until they discover the root causes.

The problem can also be presented as a tree with its causes representing the roots as illustrated in Fig. 30b

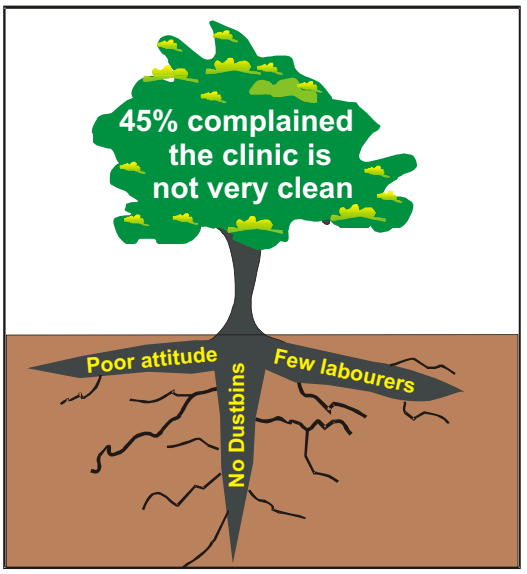


Fig 30b: Offei Tree

Select a problem and try to analyze using either brainstorming or a tree diagram.

8.2.8 Suggest/Develop Solutions

After analyzing the problem, the team should suggest ways of correcting the problem. Again, this can be done through brainstorming to gather a lot of possible solutions. You can also find out how other facilities have addressed similar problems. Some problems are easy to solve while others are difficult. The solution you choose should be practicable and within your available resources (money, material and human)

Once you get to the root causes, it becomes easy to suggest possible solution. Usually the root causes and the suggested solutions are like the two sides of a coin. In the above example, the suggested solution is to provide dustbins.

8.2.9 Implement Solution.

First develop action plan. The action plan spells out the activities to be undertaken based on the solutions, persons responsible, time frame for each activity, resources required, expected output and how monitored.

It is helpful to assign people to specific tasks even though we all work on the problem as a team. The person responsible should be clear about the task and the time to report to the team. Remember the saying that *everybody's business is nobody's business.* Always remember to make people responsible!

The table below is an example of an Action Plan

Clinic: Aboabo Health Center
Problem: 15% patients complained the clinic is not very clean.

Objective: To reduce the proportion of patients who complain that the clinic is not very clean from 15% to 10% by the end of December 2004.

Period of implementation: July- December 2004

Suggested solution	Person responsible	Time frame	Resources needed	Expected output	How monitored
Brief other staff	MA	July	Snack	Staff well-informed	Minutes
Request for funding	MA	July	Stationery	Funds obtained	Check Voucher
Obtain invoices	Purchasing officer	July	T&T	Invoices accepted	Check invoices
Purchase dustbins	Purchasing officer	August	Funds	3 dustbins procured	Inspect dustbins
Educate patients	Envir. Officer	Aug - Dec	Poster Dustbin	Patients informed	Report
Monitor compliance	Envir. Officer	Sept - Dec	Snack	Patients comply	Observe. Interview patients.
Give feedback	MA	December	Snack	Observe changes	Report

The action plan should be implemented within an agreed time period. During the implementation period indicators should be monitored to see if we are achieving our goal before the final evaluation. A Gantt chart may be of help in the monitoring of activities.

See an example below

Activity	July	Aug	Sept	Oct	Nov	Dec
Brief other staff	///////					
Source for funding	///////					
Obtain invoices	///////					
Purchase dustbins		/////////				
Educate patients		////////	////////	////////	/////////	/////////
Monitor compliance			////////	/////////	/////////	////////
Give feedback						//////////

8.2.10 Evaluate.

At the end of the agreed period we check to see whether we have achieved our goal. In the above example, we find out in December 2004 whether we have succeeded to reduce the proportion of patients who complain that the clinic is not very clean from 15% to 10%. In so doing we improve the quality of state of cleanliness from the patient's view substantially.

Fig. 31: Looking into several documents

You will have to conduct another patient satisfaction survey and compare results to see how far you have improved. Then the cycle continues.

Chapter Summary

In this chapter, we have discussed about

1. The 10 steps of the QA Cycle
2. How to apply the steps to improve quality of our services and
3. How to develop action plan to implement our activities.

The QA cycle is a tool to help us improve the quality of our services on a continuous basis. You may start from any stage but have to complete once you start. You need to be flexible and creative in using the cycle.

Exercise

Select one problem in your facility. List all the possible causes and determine the root causes. Develop solutions and an action plan to address the problem.

9

IMPLEMENTING QUALITY ASSURANCE IN A FACILITY

9.0 Introduction

In the previous chapter, we discussed the steps involved in quality improvement. It is not enough to have knowledge and not be able to apply it. We will all be happy if we can put into practice what we have learned from the previous chapter. This chapter discusses some basic steps you should take to be able to implement quality assurance in our facilities.

At the end of this chapter, you should be able to:

- ✍ state the basic steps to implement QA in your facility.
- ✍ describe the steps involved in the implementation of QA in a facility.
- ✍ Explain the role of the health care manager in QA.

9.1 Steps in the Implementation of QA in A Facility

To effectively implement a QA system in a facility, there are certain basic steps to be considered. Some of these steps can be carried out at the same time. It will be helpful to review each step periodically to ensure that the implementation process is continuous. The steps involve the need to:

1. Form a multidisciplinary quality action team
2. Create awareness among staff
3. Review present state quality
4. Develop/adapt written guidelines
5. Carry out QA training
6. Apply skills to continuously improve your performance
7. Share results periodically with other staff and clients
8. Hold regular QA meetings to plan and review performance

9.1.1 Form A Multidisciplinary QA Team

Teamwork is key to successful QA implementation at the facility level. Each member of staff has a special role to play just as a rainbow has many colors. The team should be multidisciplinary eg. Pharmacy, laboratory, Nurses, Records etc be represented. There is the need to ensure that the members are committed to work. The team shall be responsible for the implementation of QA at the facility.

9.1.2 Create Awareness among Staff

It is important that every member of staff (from the lowest to the highest) understands and appreciates the QA concept. A system to create awareness include staff durbars, departmental meetings etc. Awareness creation should continue until quality becomes part of normal routine work.

9.1.3 Review The Present State Of Quality Performance At The Facility.

Before you can take any meaningful step to improve quality, you need to know your present state of quality performance in your institution. How can this be achieved? You can get information from normal routine records, results of patient satisfaction survey etc. You then determine where you want to focus and improve performance.

9.1.4 Develop Written Guidelines / Standards

The team at this time looks at how to improve quality according to approved standards and guidelines. Existing guidelines can be obtained from National or Regional levels. They can be adapted or new ones developed. The most important thing is that all the standards and guidelines are communicated to staff.

9.1.5 Conduct Training For QA Team And Other Staff.

A start up training is conducted for QA team members. This training will cover broad areas on QA principles; setting up process and overall strategies in QA management. The team should be confident enough to initiate QA process in the facility after the training. Subsequently, there will be the need to train other members of staff. There should also be a system for systematic and continuous education.

9.1.6 Apply Skills To Improve QA.

At this point, the QA team should be in the position to apply the knowledge and skills acquired to confidently initiate the QA program in the facility. It is usually advisable to start small with indicators which are easy to monitor and see results e.g. Patient satisfaction survey. You may then expand to other areas based on what the team decides.

9.1.7 Share QA Results With Other Staff and Patients.

It is important to share the results of QA performance with other members of staff. This will help to create more awareness, increase commitment and deepen sense of

ownership among staff. For example, Performance can be presented using bar charts at staff durbar. Other creative ways can be explored to disseminate information to clients eg using patient information desk.

9.1.8 Hold Regular QA Review Meetings

Once you have initiated the process of implementing QA in your institution, there is the need to meet regularly and review your performance as a team. You can achieve this by holding regular QA meetings. Keep minutes of meetings for reference and may be used to develop action plan (refer QA Cycle in the previous chapter). Remember to appoint a Chairman and a Secretary.

9.2 The role of the Health Care Manager in QA

The Health Care Manager plays a central role in the successful implementation of the QA program. There is the need for the manager to personally show interest and inspire other staff. The manager may play some of the following roles among others:

Fig. 32: What the Leadership stands for

- Lead the staff to cultivate Quality culture in the facility.
- Ensure that the QA Team meets as scheduled.
- Provide logistics to implement QA in the institution
- Encourage training to develop staff
- Develop incentive system and strategies to motivate staff.

It is of no use to receive training in QA and not putting into practice. Management commitment is very important for successful QA implementation.

Who am I?

I always want to improve my services even with the little resources I have. I always look for creative ways to improve my services through teamwork. Above all I always make sure my services meet professional standards and to the very best taste of my clients. I always aim at excellence. ***QA***

Chapter Summary

In this chapter we have discussed the various steps we should take to implement QA in our facilities. This involves:

- Team formation
- Awareness creation
- Training of QA team
- Initiating the process
- Continuous QA monitoring and
- Overall role of the Manager

10

MANAGING CHANGE IN QUALITY ASSURANCE

10.0 Introduction

The previous chapter looked at how we can implement quality assurance in our health facilities. Introducing quality assurance in our health facilities involves change in the way we do things.

Change is a normal feature of life that we all go through. However when it occurs in an organization or a health facility, it must be managed well so as to be successful. In this chapter, we will discuss change and how people react to it. We shall also look at ways of managing change during QA implementation.

At the end of the chapter, you should be able to:

- ✍ Describe the different types of change that can occur in an organization
- ✍ List the ways people react to change and explain why they do so
- ✍ Describe how you would manage change in the implementation of QA in your facility.

10.1 Types of Change in an Organization

Various types of change can occur in a health facility or organization.

Change can be described as being imposed when there is a directive to initiate change from somewhere else. An example is when the Director General directs institutions to implement QA.

A health facility on its own can initiate change by reorganizing the way things are done or puts in place measures to improve its performance. An example is the management and staff of a facility decides to initiate change in order to establish a QA program.

Change can be described as necessary when an organisation whose survival is being threatened by circumstances, undergoes major changes to ensure its survival. An example is the privatization of a public health facility that is performing poorly.

10.2 Reactions to Change

People react to change in different ways. These include

- Those who will welcome change
- Those who will be indifferent to change
- Those who will oppose change.

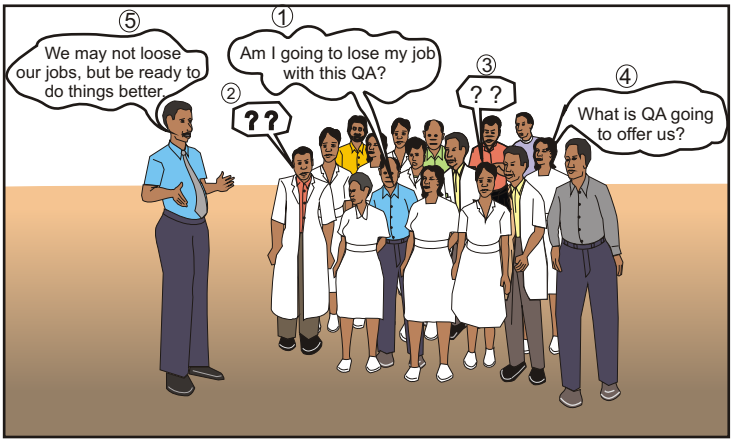


Fig. 33: Calming down the fears of workers' reaction to change

10.2.1 Reasons Why People Welcome Change

- Some people welcome change because:
- They want to be free from the boredom of their work. Possibly, they feel they are being marginally utilized and thus are looking out for more challenging opportunities.
- They expect to enjoy better conditions of service
- They expect the fall of someone's "kingdom". This occurs at the workplace when some staff feel others have undue advantages over them in terms of access to resources and privileges and the change is likely to affect the privileged negatively
- They expect recognition from the change- an opportunity to be involved more in the organization's activities.

10.2.2 Reasons People Are Indifferent To Change

People are indifferent to change because;

- They have heard of it all, being said before, and it never happened
- They see that systems and cultures are entrenched for such long periods- the organization hardly undergoes any change.

10.2.3 Reasons Why People Oppose Change

People resist change because

- They want to guard their own interests. The change threatens to deprive them of their position and privileges
- There is misunderstanding and lack of trust. This occurs when the reasons for the change, the implications and benefits are not explained to them
- They may have to acquire new skills and behaviours which they may find difficult to learn.

10.3 Strategies for Managing Change in QA

The underlisted/following strategies can be used to manage change in your facility.

- Share ideas and discuss the need for change with all staff who will be involved in the change process. This calls for frequent dialogues through staff durbars, meetings, group discussions etc.
- Use methods aimed at effecting changes in attitudes, values and skills eg conferences, study tours to sites of best QA practice to introduce and clarify new concepts and share experiences.

10.4 Ways to Minimise Resistance When Implementing Change

The following are suggestions as to how you can minimize resistance to the implementation of QA in your facility.

- Show strong commitment and leadership
- Involve all staff- do not leave it to a privileged few
- Provide data for the need to change to all staff
- Communicate the change message effectively and continuously, listen and act upon concerns from the staff
- Allay fears of staff- use consultations, discussions workshops etc
- Look for consensus decisions, encourage those likely to be affected to suggest solutions
- Do not initiate too many activities at a time
- Be transparent
- Encourage innovations
- Involve staff in standards setting
- Monitor performance and provide feedback to staff.

Chapter Summary

Quality assurance implementation in the facility can create anxiety, fear doubts and high expectations among staff. To better manage the change process the following is recommended

Managers should show commitment and leadership

Create awareness on the need to improve quality- use data

Hold meetings, workshops and seminars to explain issues, involve staff in problem solving

Undertake study tour to a facility that is doing well in QA

Exercise

How would you convince staff in your facility who resist the implementation of a QA program

APPENDIX 1A:

SAMPLE PATIENT SATISFACTION QUESTIONNAIRE

Health facility:…… Date:…… Patient No .:……..

1. How long did you wait before you saw the Doctor/Medical Assistant (MA)? Hours/minutes.

2. Was there any unnecessary delay before you saw the Doctor / MA — Yes ☐ No ☐

3. Did the Doctor/ MA examine you? — Yes ☐ No ☐

4. Did the Doctor/MA tell you what is wrong with you? — Yes ☐ No ☐

5. Did the Doctor/MA give you instructions about your illness? — Yes ☐ No ☐

6. Did the Doctor/MA tell you whether or not you need to retu — Yes ☐ No ☐

7. Did you have privacy during consultation? — Yes ☐ No ☐

8. Did you receive all the drugs that were prescribed? — Yes ☐ No ☐

9. Did you understand the instructions from the Pharmacist/ Dispensary Technician? — Yes ☐ No ☐

10. What was the attitude of the staff towards you?

Very good ☐ good ☐ poor ☐

11. What do you think of the cleanliness of the hospital and the surroundings?

Very clean ☐ Clean ☐ Dirty ☐

12. Have you attended the facility in an emergency (including night) during the last six months?

Yes ☐ No ☐

If Yes: Were you seen promptly? Yes ☐ No ☐

13. Overall, how satisfied were you with your visit today?

Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐

APPENDIX:1B

SAMPLE QA MONITORING CHECKLIST (ADAPTED FROM UPPER WEST REGION)

		Yes	No
1.	Is the general appearance of staff satisfactory?	------	------
2.	Is the staff punctual to work?	------	------
	- Is attendance book in place?	------	------
3.	Is a duty roster in place?	------	------
	- Is the duty roster adhered to?	------	------
4.	Are ward reports available?	------	------
5.	Is proper documentation on patients/clients kept?	------	------
-	Name of patient/client	------	------
	- Age	------	------
	- Sex	------	------
	- Diagnosis	------	------
	- Vital Signs	------	------
	- Signed treatment/nursing notes	------	------
	- Other: Comments		

6.	Are Health Education talks given?	------	------
	- Daily	------	------
	- Weekly	------	------
	- Occasionally	------	------
7.	Are staff meetings/durbars held regularly?	------	------
	- Are minutes of meeting available?	------	------
8.	Is the professional/Auxiliary nurses ratio satisfactory?	------	------
9.	Generally, are infection prevention measures practised	------	------
	- proper hand washing	------	------
	- Running tap/Veronica bucket available	------	------

APPENDIX:1C

SAMPLE OBSERVATION GUIDE WITH RATING SCALE

Main procedure: **Management of sick child at OPD**

Rating key:
0. The step was omitted
1. The step was improperly carried out
2. The step was well carried out

	COMPONENT TASK	RATINGS		
1.	Welcomes Care giver	0	1	2
2.	Offers Care giver seat	0	1	2
3.	Provides privacy	0	1	2
4.	Reassures Care giver	0	1	2
5.	Encourages Care giver to talk about illness/complaints eg. -Asks open ended questions	0	1	2
6.	Listen attentively to care giver eg. - Maintains eye contact etc	0	1	2
7.	Records child's complaints after listening to Care giver	0	1	2
8.	Examines child thoroughly	0	1	2
9.	Records observations on treatment sheet	0	1	2
10.	Establishes diagnosis	0	1	2
11.	Prescribes treatment	0	1	2
12.	Explains diagnosis and treatment to Care giver in language s/he will understand.	0	1	2
13.	Directs Care giver to where other services could be obtained.	0	1	2
14.	Gives /plans with Care giver date(s) for review	0	1	2
15.	Thanks Care giver for using facility	0	1	2

APPENDIX 2:

PATIENT DEFINED INDICATORS

Calculation of Indicators from Patient Questionnaire

INDICATOR 1: Proportion of patients seen promptly.

$$\frac{\text{Number of patients saying they were seen in 2 hours or less}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 2: Proportion of patients seen without an unnecessary delay

$$\frac{\text{Number of patients saying they were seen without a delay}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 3: Proportion of patients examined by the Doctor/ Medical Assistant (MA)

$$\frac{\text{Number of patients examined by the MA}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 4: Proportion of patients told the diagnosis.

$$\frac{\text{Number of patients told diagnosis}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 5: Proportion of patients given instructions about their illness from the MA.

$$\frac{\text{Number of patients given instructions by the MA}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 6: Proportion of patients told whether to return.

$$\frac{\text{Number of patients told whether or not to return}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 7:Proportion of patients having privacy during consultation

$$\frac{\text{Number of patients having privacy during consultation}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 8: Proportion of patients receiving all drugs prescribed.

$$\frac{\text{The number of patients interviewed who received all drugs}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 9: Proportion of patients understanding instructions from the Pharmacist

$$\frac{\text{Number of patients who understood pharmacy instructions}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 10: Proportion of patients perceiving staff attitude to be very good

$$\frac{\text{Number of patients saying staff attitude is very good}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 11: Proportion of patients perceiving clinic to be clean.

$$\frac{\text{Number of patients saying clinic is very clean}}{\text{Number of patients interviewed}} \times 100$$

INDICATOR 12: Proportion of those seeking emergency treatment in previous 6 months who were seen promptly.

$$\frac{\text{Number of patients saying they were seen promptly during emergency}}{\text{Number of patients who answered question 12.}} \times 100$$

INDICATOR 13. Proportion of patients feeling very satisfied with their visit.

$$\frac{\text{Number of patients saying they were very satisfied}}{\text{Number of patients interviewed}} \times 100$$

APPENDIX 3:

GLOSSARY OF COMMON TERMS

Access: The extent to which users can reach and obtain service.

Action Plan: A timetable of activities planned for a given period of time which indicates inputs required, the processes involved and the outcomes expected.

Adverse incidence: An occurrence that deviates from the normal, such as accidents occurring in the course of duty at the workplace.

Amenities: The physical features of a service that facilitate the delivery and use of the service.

Checklist: A list of items and conditions expected to be present.

Client: User of a product or service. Clients may be internal, that is, among the providers themselves, or external, that is, outside the providers.

Clinical Audit: A systemic process whereby clinicians critically examine their practice against agreed standards and modify their practice where indicated, in order to improve the delivery and outcomes of patient care.

Communication: A process by which a message is passed from a sender to a receiver. The components of effective communication are the sender, the message, the channel, the receiver and feedback from the receiver to the sender.

Confidentiality: Protection of information from persons who are not expected to have access to it.

Continuity of services: Ability of the client to receive the complete package of services that he needs from the service provision system over time, without interruption or cessation.

Customer: used interchangeable with Client.

Effectiveness: The ability of a process to produce the anticipated desirable effects.

Efficiency: Carrying out an activity or process with the least waste of time, effort and resources

Equity: Fairness in the distribution of services.

Evaluation: Assessment of the outcome of a set of processes in relation to the set objectives.

Expectation: What is seen as being satisfactory.

Facilitative supervision: Overseeing the performance of a task in such a way as to promote learning.

Gantt Chart: A chart showing when activities begin and end

Guideline: Direction on how an activity may be carried out.

Impact: The lasting effects of an activity or set of activities.

Indicator: A yardstick used to measure the level of quality.

Input: The set of people and things that are needed to carry out an activity.

Interpersonal relations: Relationship between users and providers and among providers.

Models of quality: The different angles from which one can define, monitor, measure and improve quality.

Monitoring: Continuing assessment of the progress made in the implementation of a plan or activity, with recommendations for modification of methods of as appropriate.

Mortality meeting: A meeting of health staff to examine deaths that have occurred in the facility over a period of time.

Observational guide: A list of the essential points that have to be noted when observing an activity.

Outcome: The ultimate effect of an activity or set of activities.

Output: The immediate result of an activity.

Perception: Expression of what is experienced

Perspective: Approach or point of view

Privacy: The state of not being seen or heard by a person not expected to do so. (Compare privacy)

Problem: The gap between the present level and the expected level of quality.

Process: The actual performance of an activity or set of activities.

Protocol: Strict direction on how to perform an activity. (Compare guideline)

Quality: The degree to which a product or service meets the expectations of an individual or a group.

Quality Assurance: A planned systematic approach for continuously monitoring, measuring and improving quality of health services, with available resources, to meet the expectations of both users and providers.
Quality Assurance Cycle: The steps in the implementation of quality assurance.

Questionnaire: A set of questions that help to measure the quality structures, processes and outcomes.

Safety: The degree to which a service is free from risks to the user and provider

Specifications: Guidelines that specify the characteristics of a product or material input like equipment or supplies used in health care delivery.

Stakeholder: A person or group of persons that has vested interest in a particular thing

Standard: Explicit statement of expected quality.

Structure: The set of people and things needed to carry out an activity, as well as how well they are organised to achieve results.

Supplier: The person who provides a good or service.

Technical competence: The extent to which health professional are able to apply knowledge and skills to produce professionally acceptable results.

REFERENCE

1. Bannerman, C; Tweneboah, N.T; Offei, A; Nicholas,T.A; Acquah, S; (February 2002): *Health Care Quality Assurance Manual*.

2. Brown, Lori Di Prete; Franco, Lynne M; Rafeh, Nnadwa; Haatzell, Theresa: *Assurance of Health Care in Developing Countries.* Bethsaaida, USA (USAID).

3. Donabedian, Avedis, (1996). *Evaluating the Quality of Medical Care*. Milbank Memorial Fund Quarterly 44: 166-203

4. Ghana-Denmark Health Sector Support Programme Ministry of Health-Upper West Region (September 1996): *An introduction to Quality care.*

5. Quality Assurance Programme, MOH Uganda. *Quality Assurance for Health Workers in Uganda. Manual of Quality improvement methods.*

6. Offei, A; Sagoe, K; Owusu Acheaw, E; Doyle,V; Haran, D; *Health Care Quality Assurance Manual for a Regional-Led, Institutional -based Quality* Assurance Programme. Eastern Regional Health Administration & Liverpool School of Tropical Medicine.

7. Regional Centre for Quality of Health Care, (February 2001:) *Improving Quality of Health Care. Foundations in Quality Assurance (Participant Manual)*. Institute of Public Health Makerere University Medical School , Kampala, Uganda/Quality Assurance Project, Centre for Human Services, Bethesda, USA (USAID)

8. Regional Health Administration Upper West Region (November 1994). *Health Care Quality Assurance Manual*. Ghana-Denmark Health Sector Support Programme.

9. The Quality Assurance Project (2000). *Developing standards for Quality Health Care.*

10. Weaklim, D (1994). *Development of Quality Indicators Based on Patients' Perceptions of Quality for Health Service Monitoring at Health Centres in Ghana.* Collaborative work between the Liverpool School of Tropical Medicine and the Eastern Regional Health Administration.

11. Tweneboah, N. A; Opoku, S.A (August 1998). *Implementing Quality of Care at the sub-district.* Ghana-Denmark Health Sector Support programme Ministry of Health

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