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Review In Improving Quality in Healthcare: to Makes a Satisfied Patient

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Abstract

1. Introduction

Choosing the right health service is an important part of minimizing health problems. As educators, we can now provide a solution by counseling, promoting, and establishing a health education service in various ways, ensuring good health and promoting self-sufficient resources. By establishing a health education service, individuals become entrepreneurs and play an important role in helping to improve the well-being of the community, contributing to reducing the level of disease and raising public health standards. We choose this topic because in health care services there are many standards, guidelines, and regulations that have been established over time, which can lead to high-quality service. However, the establishment of these standards does not guarantee that the services provided will ensure customer satisfaction. Discussions should be based on concepts rather than breaking down what has occurred. The three most important factors must be present to ensure customer satisfaction, and all programs should aim for great success. This is the focus of our discussion.

Power System Technology
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Methods

Factors influencing the use of patient survey data in quality improvement (QI) include their promotion and interaction. Interventions aimed at enhancing patient satisfaction with healthcare are evaluated for effectiveness. A national survey examined twelve organizational characteristics affecting patient-reported experiences across eight hospital care aspects, revealing a key relationship with hospital location convenience. This insight has led hospitals to improve patient information on facility access and traffic conditions. Additionally, the qualitative exploration of large-scale user experience survey data in local QI efforts is addressed. The paper reviews methods for leveraging patient experience data to improve healthcare quality. Innovative techniques for analyzing patient data, engaging patients in improvement initiatives, and fostering a culture centered on patient feedback are highlighted, along with the quality of data collection tools and their influence on QI utility.

Conclusion

Improvements are constantly being made to healthcare services to ensure patients' trust and satisfaction. Continuous quality improvement initiatives have led healthcare organizations to focus on pivotal attributes that increase their quality and also the higher satisfaction of patients. Discomforts, fears, and embarrassment are common emotions while patients yield themselves to healthcare services. Understandably, every patient expects quality care to alleviate those feelings. The Government of India launched a National Rural Health Mission (NRMH) to provide accessible, affordable, accountable, effective and reliable qualitative healthcare to the rural masses, especially women, children, and the poor, by integrating various existing programs. Since its launch on April 12th, 2005, the NRMH has led the healthcare provider's diffusion of quantitative healthcare; however, some gaps have permitted external public financial reviews. Patient satisfaction measurements could help identify these gaps. Moreover, satisfied patients are more compliant with treatment procedures, return to follow-ups, and suggest services to their acquaintances, hence increasing the existing patient population concerned about the financial growth of underlying healthcare (K Musunuru, 2011). So, to efficiently reduce patient dropout rates and maximize the utilization of available resources, it is essential for healthcare providers to deliver a satisfactory level. Despite the fact, a lot of individuals are completely healthy people, as well as an absolute understanding of the disease and economically prosperous, the best healthcare establishment is often difficult to be offered. There are, however, good ways to alleviate illnesses, e.g. early diagnosis and prevention, immediate therapy, and effective management. Regarding these questions, a

Power System Technology
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study was carried out to examine patient's satisfaction with healthcare during their inpatient department visits (Nkirote Ntwiga et al., 2019). The results of the survey are of the utmost importance to official contenders and leaders of hospitals participating in the survey, as the findings about the specific hospital(s) would provide a good insight into their services and patient's need. The study also subscribes to the body of knowledge about patient's satisfaction with the healthcare inpatient clinic environment, and the findings may be helpful for a better design of further research. Several aspects of Outpatient Based Quality Assessment (OBQA) are worth further study. Ambulance timing and hospital stay are found to be among the highest perceived professional care (QOPR) attributes of emergency patients; thus, greater emphasis can be placed on these factors. The absence of a restroom inside the hospital building is the largest perceived quality gap among non-emergency patients, indicating that this attribute needs immediate improvement. OBQA indicates the differential impact of the other demographic factors on perceived care quality; thus, it is advisable to consider the possible influence of these factors in any specific initiative planned to enhance care quality. OBQA is a tool to assess the perceived quality of care from an outpatient perspective. Future research should consider utilizing the OBQA tool to monitor and evaluate the quality of outpatient care. Its implementation may be beneficial not only to the hospital, but consumers as well. Future research can also focus on the inception of Outpatient Based Quality Intervention (OBQI) as a parallel effort to raise aware hospital quality in the hospital setting. Concerted attempts can also be made using OBQI, considering the valuable characteristics of the patients and the special administrative problems faced by the hospital.

1.1. Background and Significance

Review in Improving Quality in Healthcare: To Make a Satisfied Patient. The Case Study in Jakarta Hospital, Indonesia

To make a satisfied patient, continuous screening, control, and action need to be proceeded. Lecturing, instruction, and statement that are disseminated widely do not address everyone. Each person's understanding can be different from others. In healthcare, especially hospital, anything that is related to mistakes, prognoses, and patients are careful need to take an action rapidly. Simple example, a slip of a scalpel when making a surgery, a pouring of intravenous drugs that are intended to give painkiller but the patient feel traumatized, gamma handle that is often and is used to treatment is often left behind. Ignored and careless of that matter can be huge, but if it is

Power System Technology
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done immediately, the loss will be smaller. In the high cost, strict control is not become everything. There are generally things need to be done to stop that and control will be moving to be more simple and economical. Then contextually, the compilation of the standard operating procedure that is straighten by the consortium of accreditation globally would be important aspect. The intention of it is to let every control took backward that standard operating procedure and no one let slip and forgetted. The early indication to the deviation of the object can be plain because all problems are easy to overcome in it started. The more late it is known, the more complicated to solve that problem and the lose that is occurred will more amount (K Musunuru, 2011). On that context, the early indication to deviation of the patient's satisfactory is extremely necessary. To evaluate that there are various aspects influencing the satisfactory but standard and convensional are not sufficient. In the November 2007 in Jakarta Hospital, a tool to screen the standard and the other grade of indicators about the patients, thus screening tool were developed to screen 67 questions that are able to get the information about the various dimensions that influence the comfortable in quality of the healthcare (Nkirote Ntwiga et al., 2019).

1.2. Purpose of the Review

1.1. Justifies the Review

Healthcare is more than just the quality of treatment and medical interventions; it is a sum of the entire patient experience. Due to several quality reviews in the healthcare sector, this paper draws a review on patient experience as a strong determinant in hospital management to improve its quality. In most cases, patient experience contributes to other problems with all things in healthcare, time, and money.

The goal of each treatment or intervention is to return the patient to a healthy state, so is the goal of patient experience in healthcare. All patient experience, from the welcome at the reception area until the patient is released from further treatment is directed toward one goal - to make the patient satisfied (M Bastemeijer et al., 2019).

So sleepless night after surgery might be pure bad luck, or it might become worst situation a patient’s. Is this regular treatment after surgery that patients are left without assistance during the night? Is someone here when I needed the most? Concerned Nurse - two questions that possibly can prevent this problem. But usually, those kinds of broken things within one process is not treated as useful method. Conclusion is just made (C Conry et al., 2012).

Power System Technology
ISSN:1000-3673
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2. Quality Improvement in Healthcare

Quality improvement activities typically have as their objective the increase of positive patient outcomes. Some examples of healthcare-related improvement activities include decreasing the likelihood that an individual will catch a hospital infection during a length of stay, or that a hospital patient will experience decubitus ulcers, or even a case where patients scheduled for same-day surgery are guaranteed to be sent home by a certain time of day. In typical business environments, quantity certainly is differentiable from quality.

The relationship between the two characteristics was first accepted in the healthcare context. It must be remembered that, while the pursuit of efficiency can greatly improve access to and quality of medical care, the mere control of costs can limit care even though it may do little to address the ever-present problems of poor quality and utilization excess. The key words in the above statement are "while the pursuit of efficiency can greatly improve access to and quality of medical care, the mere control of costs can limit care even though it may do little to address the ever-present problems of poor quality and utilization excess." It does not say that quality improvement inherently causes healthcare costs to rise. It says that healthcare cost containment that occurs by holding conditions constant as if there is no relationship between quantity and quality will limit access to healthcare services.

2.1. Definition and Concepts

3. Key Strategies for Improving Quality

Lengthy waiting times for surgery or any healthcare service lead to irritation and impatience to the patient. For hospitals, long waiting times increase the signs of the stress factors. Patients will choose another hospital with similar quality services. This will stimulate other hospitals to make a higher quality to be the best choice hospital for patients that want an operation. To solve this problem, an inventory control method can be adapted by hospitals. Like a retailer keeps safety stocks, so do hospitals. Safety stock is a predetermined amount of rubber gloves that is either a certain percentage of the average demand. When stocks on hand are depleted, an order for new supplies is issued to the supplier and these are usually filled with a certain lead time. By involving quality loss function in the service level, healthcare service can identify the other side of quality services delivery of hospital with a priority order modulation method on waiting list as it relates to excessive patient waiting. With the assumption of the Queue Health and Safety Sub-squares and healthcare service delivery global loss function quality loss features, a

Power System Technology
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waiting loss function index is used to characterize the relationship between the stability of patient waiting and the average number of patients in the queue and the waiting time that yields the minimum of an average global loss function is estimated by modeling the global loss function of the average of two local health and safety criteria that are the fairness and departure loss functions. Then, the impact of surgery rejection on patient waiting and hospital declination is presented. Additionally, it introduces an analysis of surge soft system hospitals during a weekly period.

3.1. Use of Technology

In the conventional wisdom, to make a satisfied patient is to give medical services as client's expectation. Nowadays, it is happening a revolution in medical practice. Its point is to supply the comprehensive medical services by coordinate it with wellness, so it can improve the healthcare quality. The essential condition in this improvement effort is to satisfy patient so that it is expected that the patient may have an active role in spent the expense. From some aspects to make the patient satisfied is needed. That is from administration side, technical medical side, jargon use, up to the satisfaction level of medical services. Furthermore, the widespread of the healthcare or insurance industries, has forced the hospital management in order to increase the competitiveness, in terms of both maintaining and improving of the medical service system with the high degree of satisfaction (W Bates, 2002).

One strategy is to expand the conventional health service and another one is to enlarge the service kind and add it with the new high-tech services. To keep the competed in the industry, the hospital must continue to respond to market demand. The patient satisfaction is the key that a hospital should take care of. For that a hospital has to take the patients behavior and response in dealing with hospital. One thing that a hospital can do in order to maintain and increase value of patient satisfaction is making the effective complaint handling system. In the other side, the patient can also handle the complaints as a patient.

There are several ways in making a patient have been satisfied or pleased. The followings are needed. A humanistic approach, the hospital official should touch the patient when they are complaining. Every time a hospital has got patients complaint, this should take the serious step upon to the matter and give them the quickly solution. A hospital with proper and good diagnosis and good treatment, an educated physician, and a high-tech equipment should increase the reputation of their credibility, guarantees the patient

Power System Technology
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satisfaction as well. An informative approached. Every complaint has resolved by the hospital, this should be informed to the patient making them satisfied. As a result, patient has felt appreciator, the patient trusts to the hospital services, also the patient will always visit to the hospital.

3.2. Patient-Centered Care

In Crossing the Quality Chasm, an area targeted for improvement is patient-centeredness, or the patient's experience of illness and health care. An important dimension of patient-centeredness is respect for patient's values, preferences, and expressed needs. Yet the report did not specify how providers could take steps to understand their patients' values, preferences, and expressed needs. It is in the clinical encounter that clinicians must learn, and apply that learning, about patients' values, preferences, and expressed needs, to cross the quality and health care chasm (S. Lorenz & A. Chilingerian, 2011). If people are to receive the health care and health care outcomes they value, convergence is urgent between an understanding of that value as articulated by patients, and an operational definition for measurement representing the health care organization. False process characters people care about outcomes, but may place even more importance on the processes used to produce those outcomes and they want to feel that their perspective is heard. Some processes are vital to felt trust and understanding, giving great attention to particular processes sends important symbolic information about what is valued and is attending to the fairness with which decisions reasonably can be made.

The work of understanding patients' values, preferences, and expressed needs is conceptualized as a dynamic conversation among the patient, family, or advocate, the provider, and in the case of multi- and complex morbidities, the ongoing care network collaborating around patient care reflective of complexity. It is crucial that all participants to clinical care from the patient with MRSA to the laundry worker handling hazardous waste at the hospital be heard as valued members in the conversation. Patient-centered care is defined as care that is responsive to values, preferences, and expressed needs and that is respectful of the individual patient. To achieve person-centered care within the time-limited structure of the clinical encounter, clinicians need to understand patients' lives, their work and hearing to treatment recommendations at home, and in their communities, and the choices patients make about their care. Yet there may be evidence of a growing chasm between the rhetoric of patient-centered care and its reality, with discontent of health care continuing to mount. According to a provider-managed care perspective, effort to improve the quality of care would center on the prevention of errors.

Power System Technology
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From a patient perspective, this work of viewing the care process in terms of errors does not adequately capture patient concern; patients are more concerned with how choices and recommendations are made than with their correctness, with how their concerns and options are brought into the clinical conversation, and with how continuity is maintained across time and settings. For the disciplines and evidence quality much more the outcome of care, rather than strict adherence to treatment recommendations or the absence of diagnostic delays, for providers a broader conceptualization of quality would be efficiency to provider processes and staff work, as opposed to a focus on biomedicine. When providers and patients conceptualize health care quality so differently, without structured means for airing grievances, then dehumanizing work conditions ensue, mistakes and misconduct are covered up, and, in effect, decisions are removed from public scrutiny and accountability. The use of deception and inaccurate information is mulled over, with attendant negative consequences for retention, recruitment, and job satisfaction.

4. Measuring and Evaluating Quality Improvement

In an era of value-based health care, increasing efforts are made to achieve the most optimal outcomes, mostly from the perspective of the patient, but also making a balance with the costs and efforts to reduce harm. Consequently, among the numerous outcome and experience indicators, patient experience has also been seen as a crucial quality indicator in health care. This, since a positive association has been demonstrated with clinical effectiveness and patient safety. In the framework of commissioning for a continuous health care improvement and patient choice, the measurement and analysis of the experience were seen as a means of financial stewardship, provider governance, and the health system's public accountability. Finally, in clinical governance, measuring patient experience is believed to help identify shortcomings and improve quality of care. However, whether the measurement, analysis, and dissemination of patient experience improve health care quality remains controversial. Patient experience comprises the patients' views, perceptions, fears, and needs, obtained by a variety of methods, such as patient satisfaction and experience questionnaires, focus groups, and individual interviews aimed at health care providers, services, and systems. The former points out conditions or processes that matter most to the patients, while the latter provides feedback, making comparisons with, and a choice between health care providers. The measurement and reporting of patient satisfaction with health services were increasingly common internationally. Ideally, public dissatisfaction with health services is identified and the information obtained leads to the improvement of health services. In practice this

Power System Technology
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has not happened, partly because the providers of health services have not found the feedback useful and have not used it to improve services. Likewise, the monitoring of patient satisfaction in Dutch outpatients, radiotherapy, and dialysis facilities did not lead to the expected improvement of services. Such results revealed inconclusive or tangential associations between overall satisfaction and patients' satisfaction about expectations and aspects amenable to change. Additionally, while satisfaction is easy to score, it provides a very general description of the experience. On the other hand, questionnaires about other aspects of patient experience may be too complex and time-consuming for patients and result in a biased or low response rate.

4.1. Quality Indicators

Since the introduction of quality management there has been an increasing interest in measuring and improving quality even in the health care sector. One definition of quality in medicine could be: quality means doing the right things at the right time in the right way to the right person with the right outcome. To reach the goal of a reproducibly best possible care in accordance with the best available evidence quality indicators should be based on the best available evidence or on expert consensus. In the literature there are many definitions of quality indicators. In general quality should describe how good something is. In this context quality indicators correspond to structure-, process- and outcome quality. Structure or process indicators can only be valid if they demonstrate a positive effect on outcome. The underlying idea of quality indicators is to serve both, to systematically improve quality and to evaluate daily action.

Quality indicators can address all possible aspects of health care from infrastructure or equipment to complex clinical results. Regardless of the underlying concept, quality indicators should have been accepted by all members of the ICU team. Additionally, quality indicators should be objective. According to the RUMBA rule, quality indicators must have certain features: Relevant to the problem (at least a minimum degree of agreement must exist for each potential indicator). Understandable (the relevance for patients must be clear to medical personnel). Measurable. Behaviourable (further, indicators should evaluate actions/processes rather than outcomes). Achievable and feasible (the measurement must be feasible). Quality indicators can also address support aspects (SOPs, equipments and training). If one aims to change therapies (included in bundles) in patients with a proven sepsis, septic shock or prevention of these conditions, the majority of indicators derived in this context are process indicators. In addition, this is recognized in the sepsis campaign guidelines. Furthermore, nurses play an essential role

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in patient monitoring and care. Furthermore, nursing staff must be involved in the design and development of patient-near processes. Lastly, if it is not conveyed that a measure benefits patients, there will be problems with its implementation. So, it should also be very carefully considered which environment might be the most rewarding for the best possible care of the patient. Ideally, the same source should also be reflected in the process indicators. Otherwise, there will be problems with the acceptance of process indicators. Moreover, the underlying data of new relevant process indicators should, as far as possible, be mechanical, such that it can closely be derived or already is available from existing electronic data. The concomitant establishment of indicators in an intensive care information system or suitable electronic database is strongly recommended in order to keep the prospective data effort as low as possible and to ensure a high data quality. Subsequently collected process indicators from routine data collection will then acquaint the staff with the handling of quality indicators and the related data processing. It is probably useful to start with a smaller number of process indicators that are, however, very closely relevant to the problem (Braun et al., 2010). In principle, measurement of all indicators should take place beyond the everyday critical actions on fixed days, since the quality of care may otherwise be influenced. Accessories used for the measurement of indicators should be readily available at the bedside and their use should not impose an inadmissibly high additional time burden on the part of the medical and nursing staff. Consumers must be informed in simple terms of a new indicator of quality and its measurement method.

4.2. Data Collection Methods

Quality in healthcare, and in particular, patients' perspective of how they perceive quality in healthcare is not a straightforward thing to measure. Various different mechanisms being tested have shown that there is variability in the results that they produce depending on the care that is being measured, institutional and contextual factors. However, the most important methodological lesson of the study is that more concentration should be put on how data are to be collected and managed for analysis (E Green et al., 2012). The process of setting up a qualitative "quant" to investigate patients' experience of care exposed a whole range of practical issues particularly in terms of what types of data should be collected, and how data should be collected which have not been so much of an issue in other attempts to test a method of evaluating quality in healthcare.

The methods used to collect data were an exit survey for patients seeing their general practitioner or practice nurse, and audits comparison of these audits findings with the

Power System Technology
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findings from the organization's Quality and Outcome Framework (QOF) were used to validate the methods or to benchmark the results QOF is a financial reward system that measures quality of care in four domains, clinical, organizational, patient experience, and additional services that also takes into account patient reported outcomes. In addition, in the last two years, practices have been required to collect patient experience data centralizing QOF changes that occurred at the same time that the present study began (Lorraina Hytiris et al., 2017).

5. Conclusion and Future Directions

Healthcare quality is a complex measure comprising multidimensional attributes that cannot be measured directly. This complexity is further complicated by differing perceptions of multiple stakeholder groups. In order to assess and improve service quality, there is a necessity to understand patient expectations of it. A conceptual model is proposed leveraging the extant service quality literature that makes modifiable components of care and service explicit in affective and elective domains. It is important for this setting given that it must serve the health care needs of patients from the cradle to the grave. These patients visit GFC due to acute illness, reoccurring chronic disease, genetic predisposition, preventive health care, or for purely diagnostic therapeutic services. The model is futures work discussed in metric identification, definition, and finally performance to promote the continuous improvement and visibility in care provision (Verma, 2007). Healthcare quality is a complex measure that comprises many various attributes that are mainly not directly measurable. It necessitates the assessment of multiple attributes like comfort, access, short waiting times, courtesy and friendliness of the nurses, and so on, in order to create a composite measure (K Musunuru, 2011). Quality is further complicated by the fact that differing stakeholders have differing perceptions and expectations of healthcare services. Even further complications exist since patients are unique and what constitutes quality care to one patient may not to another, and in fact, this care could be considered the opposite of high quality. This is an expectedly difficult research endeavor given this intricate, multifaceted setting. These problems are escalated when trying to deliver quality health care in the setting as there is a complex constituency. Patients present with the entire range of acuity from the cold symptoms to advanced life threatening diseases. Recommended services or prescriptions for care can run the gamut from the low expectations of expectant observation to the urgent needs of immediate surgical intervention. Moreover, many patients present with special needs because of language barriers or social economic status. IMS Perinatal is a women's specialty practice providing gynecologic, obstetric, prenatal, and maternal care.

Power System Technology
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It must provide these services to a largely rural population, many of whom do not have access to specialized healthcare. Furthermore, IMS Perinatal serves a population with a high illiteracy rate who speak predominantly Spanish. It is the modifiability of service quality attributes like those proposed affective and elective domains that can be useful information to GFC as Drs. strive to improve care processes and ultimately attain the desired outcomes.

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