Project Study

SIR GANAGARAM HOSPITAL

NEW DELHI

(SGRH)

(Feb 18th to May 17th, 2019)

CARETAKER SATISFACTION STUDY

(OPD)

by

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Under the guidance of

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ACKNOWLEDGEMENT

1. I am thankful to Dr Raja Joshi, Chairman, Department of Paediatric Cardiac Sciences, Sir Ganga Ram Hospital, New Delhi for having provided an opportunity to carry out a caretaker Satisfaction Study (OPD) at Sir Ganga Ram Hospital, New Delhi thereby providing a valuable exposure to operational and logistics aspects hospital operations & caretaker issues in a reputed multi-speciality hospital
2. The professional guidance of Dr Raja Joshi coupled with the full hearted support of his erudite staff rendered the OPD Caretaker Satisfaction Survey a valuable learning experience.
3. I also place in great esteem, the able mentorship of Mrs Divya Aggarwal, Associate Professor& Assistant Dean (Academics and Student Affairs), IIHMR, New Delhi has been instrumental in successful completion of Caretaker Satisfaction Study at Sir Ganga Ram Hospital, New Delhi.
4. I also acknowledge the significant contribution of Lt Col Dheerendra Pant, Lt Col SK Nair and Lt Col Gopendra in facilitating data collection, compilation and finalisation of this study as they were also doing their internship and dissertation from the same department.

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LIST OF ABBREVIATIONS

1.	SRGH	Sir Ganga Ram Hospital
2.	CHD	Congenital Heart Defect/Disease
3.	OPD	Out Patient Department
4.	IPD	In Patient Department
5.	ICU	Intensive Care Unit
6.	wef	:

ORGANISATION PROFILE

1. Sir Ganga Ram Hospital is a 675-Beded multi-speciality state-of-the-art Hospital in India. It provides comprehensive Healthcare services, and has acquired the status of a premier medical institution. It is the only hospital in the private sector that has maintained nearly 100% bed occupancy due to its reputation of providing the highest level of medical services to caretakers from Delhi and neighbouring states. The hospital was founded initially in 1921 at Lahore by Sir Ganga Ram (1851-1927), a civil engineer and leading philanthropist of his times. After the partition in 1947, the present hospital was established in New Delhi on a plot of land of approximately11 acres. The foundation was laid in April 1951 by the then Prime Minister of India Shri Jawahar Lal Nehru and inaugurated by him on 13 April 1954.
2. Sir Ganga Ram Hospital in India continues to maintain its charitable character in accordance with the wishes of its founder. Funds generated from the hospital services are partially utilised for providing free health care to the poor and needy caretakers. All development activities of the hospital are financed from internal resources, with no financial assistance provided by the government or other external agencies. The Sir Ganga Ram Hospital is committed to make available 20% beds of total strength for admission of indigenous and financially weaker section of the society. On these beds all facilities (boarding, lodging, investigations, medicine and operative procedures) are free.
3. In addition to that, Sir Ganga Ram Hospital, New Delhi are running specialised regular OPDs for all disciplines where

caretakers are seen free of charge. 40% of all the investigations for the OPD caretakers are free of charge. These facilities are provided strictly on a first come, first serve basis in accordance with laid down government & hospital policies.

Mission Statement

4. Sir Ganga Ram Hospital is committed to provide world class healthcare, teaching, training and research by a team of highly qualified doctors, dedicated nurses, para-medical and non-medical staff with the help of state-of-the-art diagnostic, therapeutic services in a comfortable, caring and safe environment at an affordable cost to all sections of society including free treatment to the economically weaker section as per vision of the founder.

Vision

5. To be leaders in healthcare delivery, medical education, training and research and to meet the changing expectations of the community.

Department of Paediatric Cardiac Sciences

6. Paediatric Cardiology & Cardiac Surgery services at SGRH provide a full spectrum of evaluation, diagnosis and management of congenital and acquired Heart Disease including cutting edge interventional therapy from foetus to adulthood. Services are provided by a team of Paediatric Cardiologists and Paediatric Cardiac surgeons specialised in the care of infants, children and young adults who require cardiac care. Paediatric Cardiac Surgery Services are provided by highly trained and dedicated Paediatric Cardiac Surgeons specialized in neonatal and paediatric cardiac surgeries and ably supported by trained

Paediatric Cardiac Anaesthesiologist. Pre-procedure assessment and evaluation of the child and infant / neonate with congenital cardiac defect is done thoroughly and efficiently at SGRH. The department boasts of a dedicated high end echocardiography system capable of performing 3D/4D echocardiography. Services for Level III foetal echocardiography enables precise prenatal detection of congenital heart disease in the foetus, which allows appropriate planning of postnatal management of the baby. Facility of Trans-oesophageal Echocardiography allows for intra-op assessment of caretakers and assessment of device closures in cath lab. Their paediatric cardiology faculty perform both diagnostic and therapeutic interventional procedures in children and infants including Balloon Septostomy, Balloon Valvuloplasties, Device closure of ASD, VSD & PDA and Stenting of Critical lesions. Paediatric Cardiac Surgical Services range from highly complex neonatal cardiac surgery (viz Arterial Switch Operation) to paediatric cardiac surgeries and surgical management of adults with congenital heart disease. Backed up by anesthesiologists and intensivists and state of art infrastructure, safety of the child is always ensured.

7. **Spectrum of services provided includes:**
    a. Paediatric Cardiac Surgery:
        i. Neonatal Cardiac Surgery (Arterial Switch Operation, Infra-diaphragmatic TAPVC Repair, Truncus, Premie PDA ligation).

ii. Paediatric Cardiac Surgery (Surgical Repair of ASD, VSD, TOF, Pulmonary Atresia, DORV, TAPVC, Complex Single Ventricle surgeries etc.).
iii. Surgery for Adults with Congenital Heart Disease.

8. **Pediatric Cardiology:**
   a. Noninvasive:

      i. Evaluation of heart murmurs.
      ii. Diagnosis and management of congenital heart defects.
      iii. Foetal cardiology.
      iv. Management of heart failure.
      v. Diagnosis and management of rhythm abnormalities.
      vi. Hypertension and Obesity in children.
      vii. Pulmonary Hypertension clinic.
      viii. Acquired heart disease (e.g Kawasaki Disease).
      ix. Management of chest pain and syncope.
      x. Cardiac evaluation and prevention counselling for healthy lifestyle.

   b. Invasive :
      i. Diagnostic Cardiac Catheterisation and Angiography.
      ii. Device Closures of Structural Heart Disease (ASD, VSD ,PDA, AP window).
      iii. Balloon Pulmonary Valvuloplasty, Balloon AortivValvuloplasty.
      iv. Balloon Dilatation of Coarctation, Balloon Angioplasty.
      v. Balloon Atrial Septostomy, Blade Atrial Septostomy.

vi. Pulmonary Artery Stenting.
vii. Stenting of critical Lesions in neonates and Children (PDA stenting).
viii. Coil closure of PDA and Collateral arteries.

c. Facilities Available **:**
   i. Dedicated Paediatric Echo Lab equipped to perform Neonatal, Paediatric &Foetal Echocardiogram.
   ii. Facility for 3D/4D echocardiography.
   iii. Paediatric Friendly Operation theatres and Cathlab.
   iv. Dedicated 8 Bedded Paediatric Cardiac ICU.

INTRODUCTION

9. Health Care Services (HCS's) have an inordinately exponential manner in which their utilization has increased over the past decade in India. It has affected all low-income and middle-income households, with an express demand increase &focus gravitating towards the following
    a. Quality & quality of care received & its contextual relevance
    b. Degree of clinical knowledge and method utilised to solve a health problem
    c. The sensitivity of the system to realize "non-health needs" and match expectations to care taker/patient involvement
10. Care taker/Patient satisfaction is thus not only influences the sustainability and endurance of services it is an important influence which safeguards quality of care. The vital and indispensable element of communication between provider and patient is inexorably linked to the following
    a. Gravitation to patient concentrated attitudes, of collaboration and negotiation, are well en-route to replacing the old-fashioned "protective paternal model".
    b. Active "provider-patient" interfaces lead to better decisions as they are more likely to better comprehend the limits of possible medical interventions.
    c. Notwithstanding the growing indication regarding the impact of provider-patient communication on health outcomes and caregiver behaviours; the data and its interpretation has been notorious and sometimes abysmally sub-optimal in a variety of situations. Thus, it is imperative to study these associations and their effects in very specific

and well defined frameworks which play a part in perceived quality of healthcare.

d. These can be
    i. Health systems per-se
    ii. Attitudes towards healthcare
    iii. Discriminations, and traditional beliefs

11. Another associated purpose is to be able to see the leeway of the in-situ system to graduate from “Health Professional CentredCare” to a "Family-Centred Care “(FCC) is a viewpoint of care centred on organizationset in balance between the family and the health care team in delivering care to a sick neonate. In India, this represents itself as follows,

a. This collectiveenterprise is grounded on self-worth and reverence, factssharing, and the kinfolk’ssharing through their learntskills in providing importantnew-bornattention.
b. There are often and frequent parents reporting distress, frustration, and alienation if they are excluded from taking care of sick neonates. Contrary, if they are allowed to be involved in care, get timely and unambiguous communiqué about their new-born’s status from health care personnel they understand display reduced anxiety.
c. The importance of placing a Caretaker Satisfaction Survey was thus vital as it became imperative to be able to asses if the Indian filial caretakers are capable of actually taking the transient step towards FCC as Implementation of FCC has been shown
    i. To decrease the length of stay in the hospital for pre-term babies

ii. Improve their well-being
iii. Allow better allocation of human resources, and
iv. Enhance parent-infant bonding

12. The advantages accrued to the patient/caretaker and the medical staff are plainly visible in
    a. Display long term positive effects on IQ and attention spans among new-borns born with neurological vulnerability
    b. Decreasesa baby's trauma and discomfort
    c. Have maternal benefits such as preventing post-partum depression and more positive interactions with their infants in the first 6 months/ post intervention.
    d. Breastfeeding becomes possible and frequent when mothers are present in the NICU, which in turn contributes to positive infant health outcomes. Breastfeeding is found to protect against child infections and increases in intelligence, and reductions in overweight and diabetes
13. A real time assessment Caretaker Satisfaction of the previous cases handled in the institute was thus a requirement for being able to generate a clear picture.

GENERAL OBJECTIVE

14. Identification of QR's
    a. No immediate or retrospective follow up of non-medical issues which effect caretaker satisfaction even as treatment density has increased.
    b. The area of Caretaker Satisfaction w.r.t the non-medical variables are a non-demarcated, zero specialsation area for the department.
    c. Defines the interactive spread of opinions within the caretaker's parent's community. These are general kept well hidden and guarded from the treating staff.
15. General Objectives
    a. Objective 1: To carry out caretaker satisfaction survey on non-medical parameters affecting the caretaker.
    b. Objective 2: To use gaps in the information to identify emotive issues generally suppressed at the caretaker end.
16. Specific Objectives
    a. Objective1: To carry out a Survey on specific, non-medical aspects which have a direct bearing on caretaker satisfaction for the Paediatric Cardiac Science Department.
        i. Details of variables and corresponding items of information attached as **"Appendix A"**to this report.
    b. Objective 2:
        i. Use both non recurrent&recurrent feedbacks to identify possible causes of genesis/ triggers which on identification can be used for the betterment of caretaker satisfaction in future.

ii. This is a deduction oriented objective committed to identifying& bringing forth issues which can assist in developing strategies by which non-medical, irritant issues can be dealt with effectively.

REVIEW OF LITERATURE

17. Studies all over the world have been conducted to ascertain the possibility of how the Caretakers of pediatric / neo-nate patients can be encompassed into processes which afford for a swifter recovery. This takes immense value when seen in consonance with the exponentially growing demand for these medical services. This is possible only if we have a measure of how the Caretakers (in this context the parents) view the existing facilities.

18. [1] One such latest study was conducted at Ram ManoharLohia Hospital New Delhi in 2012. It was called," Acceptability of a family-centerednewborn care model among providers and receivers of care in a Public Health Setting: a qualitative study from India". It found that FCC was a possibility in India provided the caretakers were supported by a given standard of organization, which they perceived as trustworthy to some level.

19. [2]Department of Surgery, Dr. D. Y. Patil Medical College, Pimpri, Pune, Maharashtra, India conducted a patient satisfaction survey with the aim of ascertaining how it helps our health care delivery system (the patient, the health care giver and the organization)?This study was study conducted on 200 patients from August 15 - January 2016 among patients admitted . A predesigned structured questionnaire was based on relevance of questions to healthcare services on various aspects of care. It concluded Patient Satisfaction Survey can support alterations in health care delivery with organizations and entities. Thus leading to enhancement in patient care.

20. [3]An indoor patient satisfaction was done in a super-speciality Uro-gynaecology hospital in Nagpur, Central India in a

private tertiary level surgical hospital for 4 months from January to April 2017 to evaluate the patient satisfaction for indoor facilities. It concluded for changes to be effective there is a prime requirement for conducting Patient satisfaction Surveys. These can promote improvement in practice and also respond to patient expressed needs. The study indicated

a. 88% respondents found the service by reception staff as excellent.
b. 64% were admitted and allotted rooms within 30 minutes of arrival.
c. 94% said that the time given by doctors was satisfactory.
d. 96% were extremely satisfied with the disease description,.
e. 98% said that the perception of efficiency of doctors and the details of investigations discussed were excellent.

21. [4]An article published on Patient **perceptions and expectations from primary health-care providers in India assesses** indices of Patient Satisfaction at the level of the family physician which is usually the first point of contact between the patient and the health-care system. The study was carried out over a 6-week period starting from 19th August to 30 th September, 2010, at a Private Primary Health-Care Center in a semirural area in New Delhi, by exit interviews in the form of a questionnaire from patients randomly selected. The findings showed that

a. 83.58% of the patients were satisfied with the general experience and the behavior of the health-care provider
b. 85.9% were satisfied with the treatment and care provided

c. 65.5% were satisfied with the physical environment of the clinic.
d. However, the percentage of patients who would recommend the facility to their friends was overwhelming (94.6%)

METHODOLOGY

22. Specific research design. A typical, set pattern approach would not have shown a conclusive result in this case. The following factors were considered in this case for the overall design.
    a. Focus was on a high degree of accuracy, reliability &validity. This was important as
        i. The department is a “super specialist field” and the treatment / operations are focused on getting the caretaker well as against maximizing numbers as a prime priority.
            1. The high cost of treatment and the delicate health of the caretaker is a major consideration for the low numbers population which considers these treatments.
            2. The emotive baggage which accompanies these is also tremendous and in all cases (success, failure, extended treatment & unanticipated expenditures) leads to the parents swinging from one end of the spectrum to the other (all praises

and all forgiving to completely caustic and critical).

b. Identification & minimization of biases & subjectivity at both the surveyor and respondent end becomes critical. The following biases were observed along the run of the survey.
    i. The preponderance of the Patrearchial/Matrearchial Feudal System.
        1. Many a times, the response to questions to be answered by the father/mother were stunted by the presence of the Mother/Father-in-law.
        2. The “in-law’s” being the functional head of the household did not permit the daughter in law to answer.
    ii. Unwillingness to disclose/ part with any information regarding the procedure for the following reasons.
        1. Non-disclosure of Financial sources
        2. Fear of illegitimate use of data, or,
        3. Traditional Biases of stigma attached to discussing medical problems & treatment in the Indian culture.
    iii. Caretaker classification (at the surveyor end). All the caretakers which were covered under the survey were classified as “children” with no distinction being made to their,
        1. Gender
        2. Age (Child/Adolescent/Youth)
        3. Handicapped Caretakers

c. Keeping in view the limited time and the financial circumspection the following design aspects were palpably unambiguous
    i. The time period of the study would have to be hemmed in with the working of the hospital staff.
    ii. The time for which the memory recall could be banded was a maximum of January to May 2018.
    iii. The location of the study had to be inclined within the institution.

d. Finally, maintain a practical component link between each design component the design of the survey was a synthesized blend of **"Cross Sectional, Observational Study"**.

23. Study Area.

e. Department of Paediatric Cardiac Sciences , Sir Ganga Ram Hospital .

24. Study Time Period.

f. One (01) Year {01 May 2018 to 30 April 2019}

25. Study Population.

g. OPD cases presenting in the study area.

26. Inclusion Criteria. As under

h. All cases which presented themselves in OPDwef 01May 2018 to 30 April 2019

i. All cases admitted for diagnostics, as also, surgical intervention in OPD.

27. Ethical Considerations. The study has been reviewed and approved by Student Research Board of IIHMR, New Delhi. As the study is based on primary data gleaned from

secondarydatainformation base and is personal and confidential in nature, it has been withheld by the Department. However during collection and collation of the data a system of “Double Blinding “was put in force wherein the blinding was done at the collectors end and the compilers end.

28. Sampling Technique. The Sampling was restricted to the OPD cases pertaining to the Study period. Thus the sampling was **Convenience Sampling** where all the OPD cases were to be considered and covered. Details of the same are given as under,

    j. Total number of cases which presented themselves to the Department are 4,666
    k. The total number of cases which came to the OPD for treatment is350(our Sample size).

29. Method of Data collection. As a major portion of the time allocated was spent in gleaning information from paper records, formalising, presenting and approval of the data, digitalisation of paper records to collate secondary data it became vital to speed up the collection of the Primary data. The optimization of time and effort was to be defined by the availability of caretakers on site and over the telephone. This effectively took away any governance over the tempo which could be established for speeding up the data collection conclusively. Thus a meld of utilizing Personal Interviews, Questionnaires & telephonic interviews based on Questionnaires (prime source of data collection) was used

    l. Interviews. Were directed for those caretakers who were coming in for post op follow up’s and for parents of those

caretakers who were being discharged. The intention was to be able to,

i. Concentrate more on revealing issues and underlying reasoning
ii. Probe “why” they feel such issues, opinions and needs exist
iii. Providing caretakers with a formal opportunity to express their views
iv. Spending time and resources on specific cases for attention if needed.

m. Questionnaires. Were constructed to be able to give denoted line of congruent questioning to one and all respondents. It was also tailored to be able to assist in & be able to be recorded during the telephonic interviews. The whole idea was to maintain,
    i. Standardisation of questioning.
    ii. Commonality of response.
n. A combination of the 2 methods was approved by the HoD (Dr Raja Joshi)
    i. Survey was to use a mix of “closed questionnaire & direct interview” techniques and access erstwhile cases using the telephonic interviews.
o. Data from responses were compiled using MS Excel & based on above arrangement, scales were defined and were to be quantified on **(WEIGHTED AVERAGE METHOD**)the following basis
    i. Excellent to poor (staggered association 5 to 1)

ii. The weighted average of each variable depending on the score tallied will depict a proportion with respect to number 5 indicating its standing within the perception of the attending population.

p. These can be used for quantitative SWOT ANALYSIS of each sector (if the numbers were large enough to allow for a fair degree of randomness).

Note:-

30. Due to the time constraint, sensitivity& the undeterminable aggregated of respondents it was suggested byto by Dr Raja Joshi that the data collection be done in the department premises, on a standalone computer, and keeping with the ethics of “patient confidentiality” be kept in on the Chairman’s personal laptop.

31. A“pre-test” was conducted to proof the questionnaire on 30 cases for ascertaining the validity of the questionnaire.

EXECUTIVE SUMMARY: RESULTS

33. This report presents the results of the Sir Ganga Ram Hospital Caretaker Satisfaction Survey for the Paediatric Cardiology & Cardiac Surgery Department (OPD)has been planned to cover for a one year timeframe with effect from 01 March 2018 to 28 February 2019.The survey was carried out in a composite format incorporating structured interview, questionnaires and selective scheduling (telephonically).

34. For this report, 417caretakers were approached out of which 350 responded to the survey bringing the survey response rate to 83.93%.

35. The following is a summary of the results.

    a. It would be pertinent to note that some caretakers did not respond to all questions on this survey.
    b. The response in the case was from the caretakers of the children.

36. Of the total 350caretakers who responded to the Caretaker Satisfaction Survey and completed the optional section at the end:

    c. 100 % patients were from India.
    d. Age ranges for the patients varied from 1 month to 10 years.
    e. 22% had annual incomes of BPL range.
    f. 4% had corporate insurance support.

37. The following is a summary of the findings for the under-mentioned department/service area.

    g. Admission and Discharge Services.
    h. Treating Physician Services.
    i. Diagnostic Services.
    j. Miscellaneous points

38. Each of the department / service area has been summarised and represented in **weighted averages of all responses** for particular questions.

ADMISSION

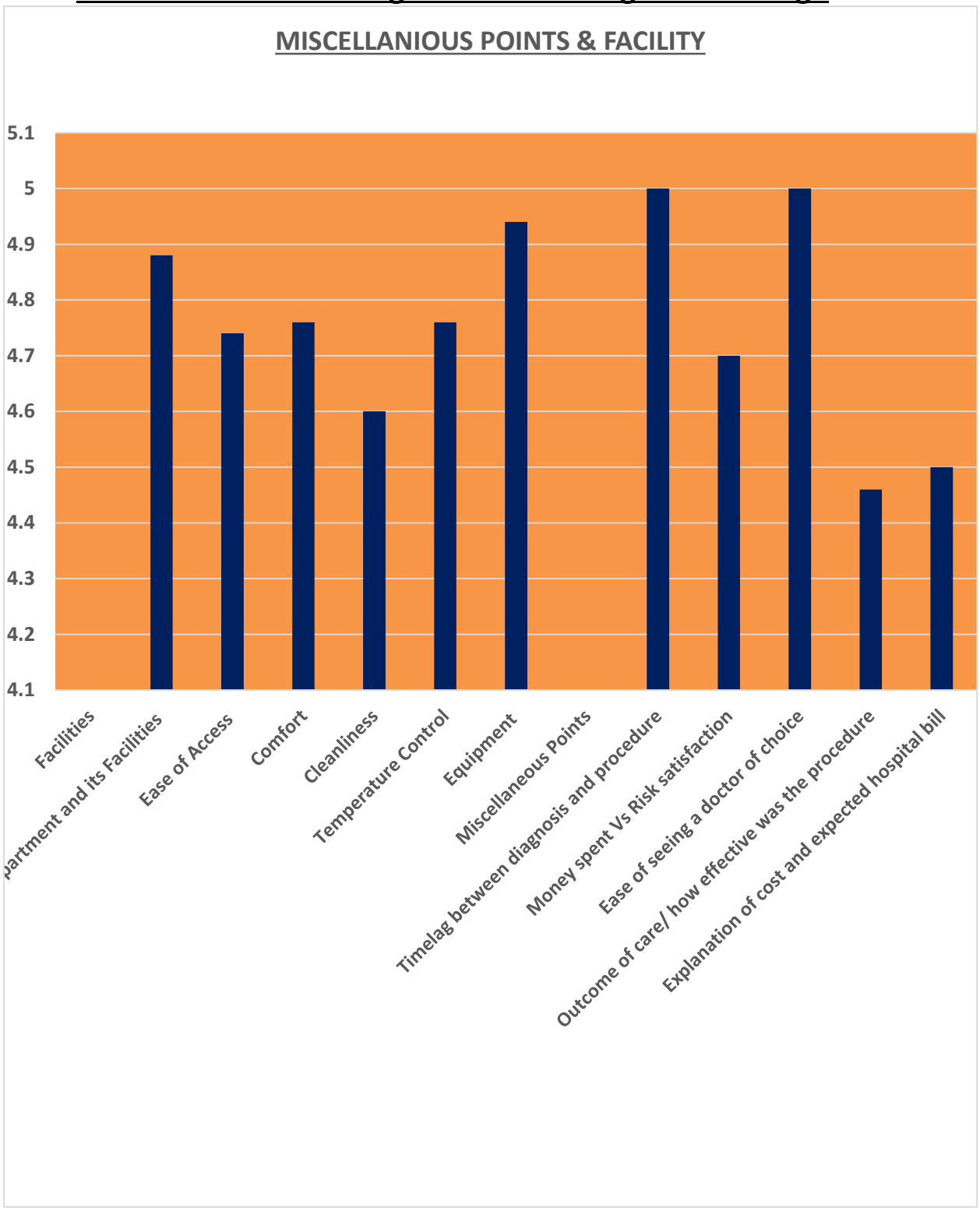
&

DISCHARGE SERVICES

ADMISSION & DISCHARGE SERVICES

39. All 350caretakers completed the survey for the admission/discharge process.
    k. Higher range of satisfaction
        i. Satisfaction with the admission process rated 4.26 out of 5 and
        ii. Satisfaction with the discharge process rated 4.04 out of 5.
    l. The Lower range of satisfaction are
        i. 3.96 for clear understanding of the bill
        ii. 4.04 for overall rating of discharge process
        iii. 4.14 for information provided for billing process
40. Margins for improvement are present in
41. 20.8% in Clear understanding of the bill
42. 19.2% in overall rating of discharge process
43. 17.2% in information provided for billing process

Admission and Discharge Services : Weighted Average



TREATING
PHYSICIAN SERVICES

TREATING PHYSICIAN SERVICES

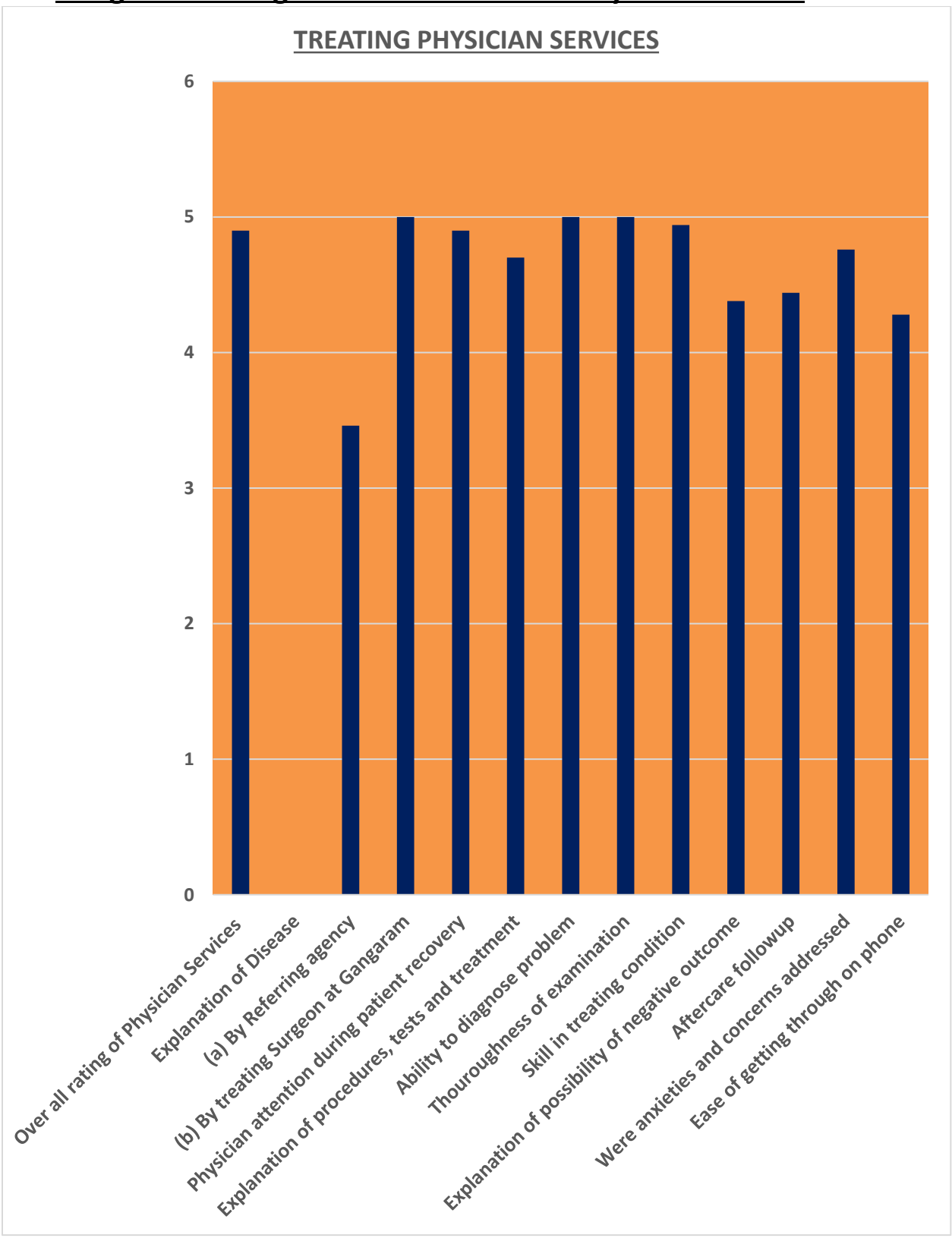
44. Overall satisfaction with physician services was extremely high(4.957 on a 5 point scale). Caretakers were more than satisfied with the physician's ability, thoroughness, skill, explanation of tests, procedure.

45. All 350caretakers completed the survey for the admission/discharge process.

    a. Higher range of satisfaction
        i. Ranged from 4.28 for ease of getting through on the telephone to a straight 5 in case of treatment, ability & thoroughness.
    b. The Lower range of satisfaction here is
        i. 3.46 in the explanation of disease by the referring agency.

46. Margin for improvement is present to an extent of30.8% in explanation of disease by the referring agency.

Weighted Averages - Satisfaction with Physician Service

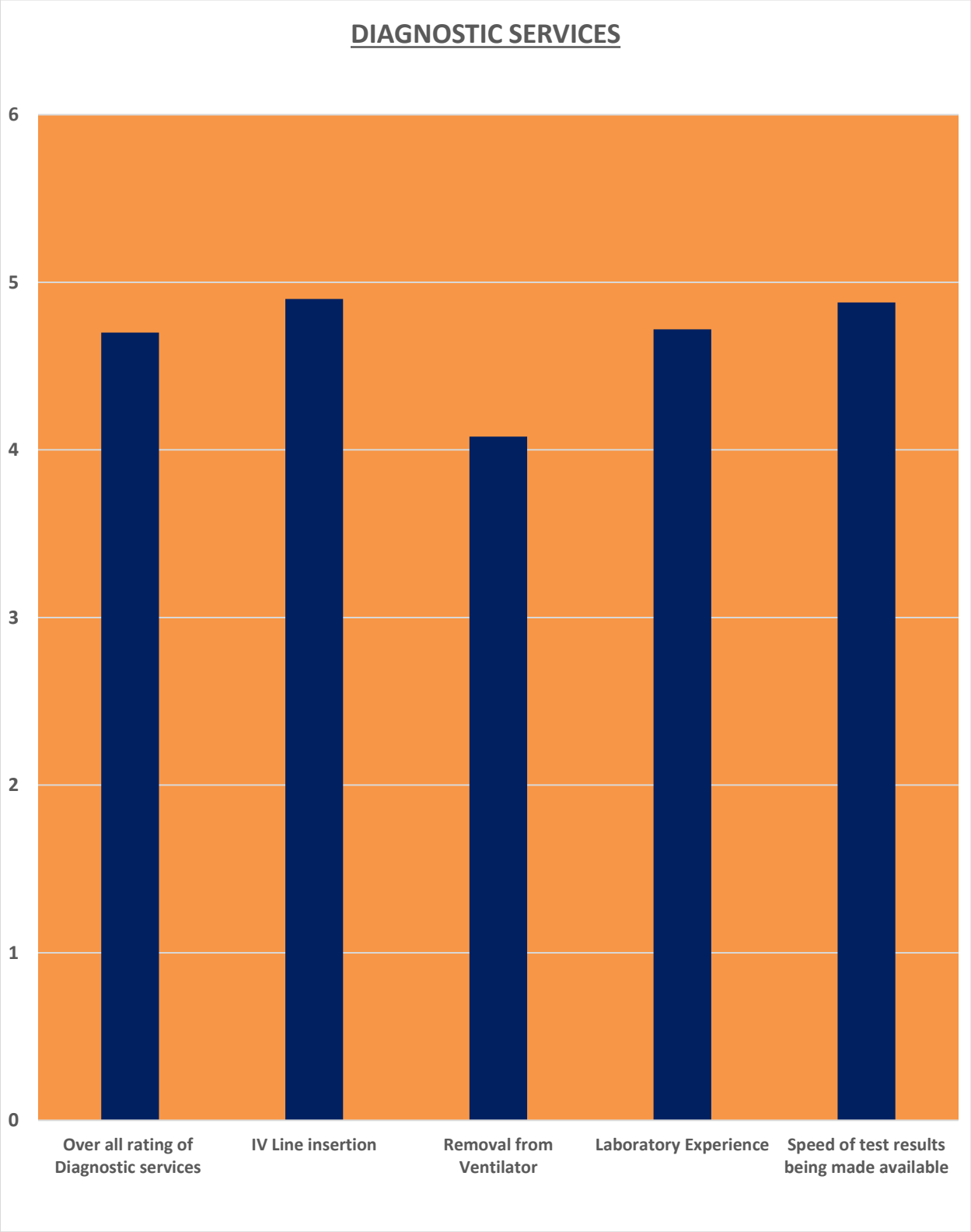


DIAGNOSTIC SERVICES

DIAGNOSTIC SERVICES

47. Overall satisfaction with diagnostic services was extremely high(4.596 on a 5 point scale). Caretakers were satisfied with the speed and quality of experience.
48. All 350caretakers completed the survey for the admission/discharge process.
49. Higher range of satisfaction
50. Ranged from 4.9 & 4.88 for IV line insertions and speed of test results being made available
51. The Lower range of satisfaction here is
52. NIL.

Diagnostic services: Weighted Average Graph



MISCELLANIOUS POINTS

MISCELLANEOUS POINTS

53. All 350caretakers completed the survey for the Miscellaneous Points. This was covered in 2 parts

a. Facilities. The average rating for the section was 4.78 out of 5.

ii. Higher range of satisfaction

1. Satisfaction with the equipment availability & upkeep rated 4.94 out of 5.
2. Satisfaction with the department & facilities rated 4.88 out of 5.
3. Satisfaction with the ease of access to & fro in the department rated 4.76 out of 5.
4. Satisfaction with the temperature control rated 4.76 out of 5.
5. Satisfaction with the comfort (paitent)rated 4.60 out of 5.

iii. The Lower range of satisfaction are

1. 4.6 for cleanliness (relative).

b. Miscellaneous points. The average rating for the section was 4.73 out of 5.

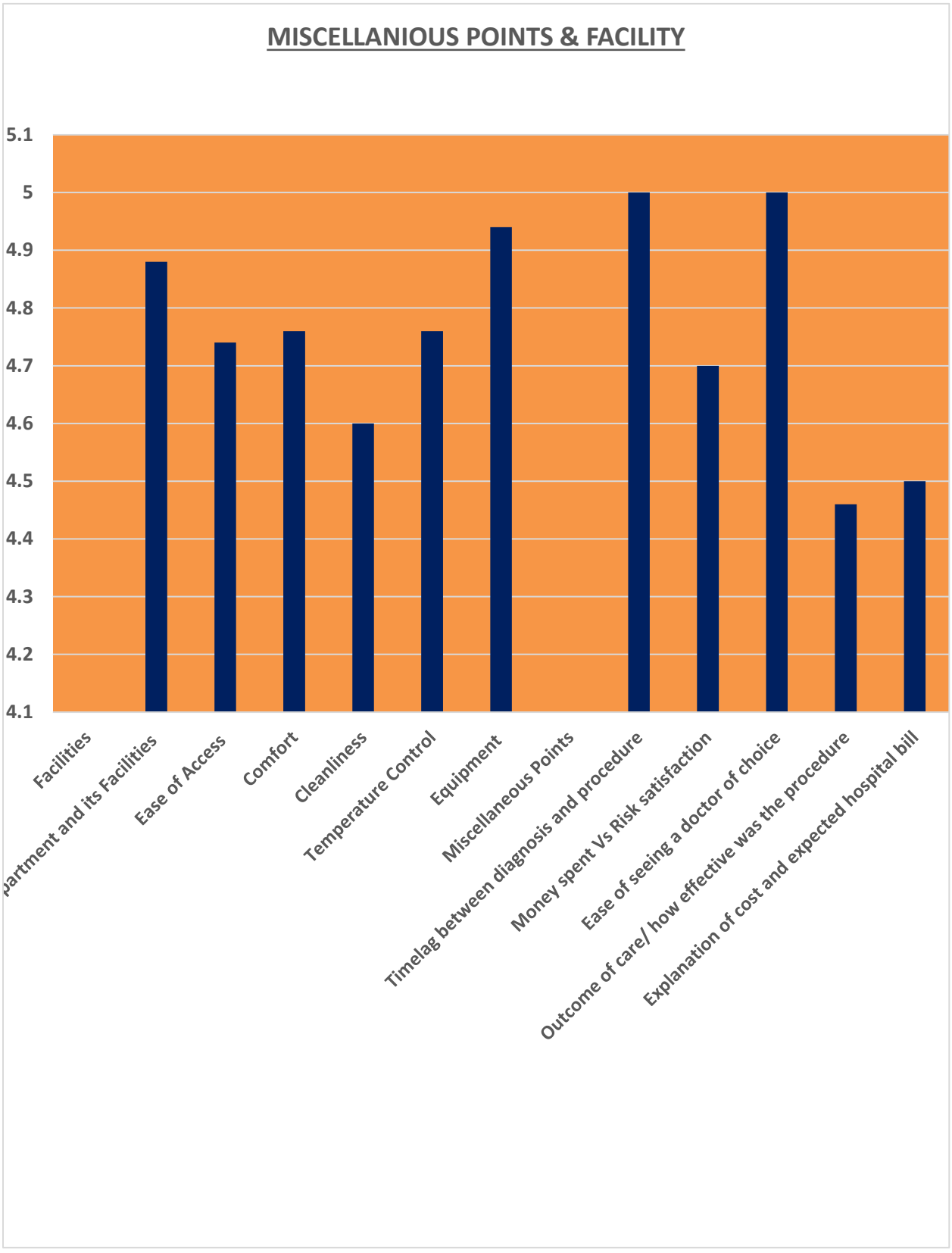
iv. Higher range of satisfaction

1. Satisfaction with the Timing between Diagnosis &Procedure rated 5 out of 5.
2. Satisfaction with ease of seeing a doctor of choice rated 5 out of 5.
3. Satisfaction with the money spent vs risk satisfaction in the department rated 4.70 out of 5.

v. The Lower range of satisfaction are

1. Satisfaction with the outcome of care rated 4.46 out of 5.
2. Satisfaction with the costs involved rated 4.50 out of 5.

Weighted Average Graph: Miscellaneous Points



DISCUSSION :SURVEY DATA

54. The tabulated data of all 350 caretakers is being placed in the succeeding tables to ensure numeric perspective of the survey undertaken

55. Admission & Discharge Services

ADMISSION & DISCHARGE SERVICES							
	Completely Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Completely Dissatisfied	NA	W. Avg
Rating	5	4	3	2	1	0	
Over all rating of Admission services	231	49	35	14	7	14	4.26
Staff attention	231	49	28	21	7	14	4.24
Wait time	245	35	21	21	14	14	4.24
Explanation of procedures	238	49	7	28	14	14	4.22
Personality of Admitting Staff	238	49	14	28	7	14	4.26
Information provided on billing process	210	77	14	14	21	14	4.14
Overall rating of Discharge Procedure	217	56	21	14	14	28	4.04
Clear Understanding of bill	203	56	21	28	28	14	3.96

c. Reason for dissatisfaction.

vi. The basic reason was the willing/ unwilling lack of understanding of the billing.

vii. The following practices were entwined into the establishment of this sensitivity

1. The lack of a realistic all inclusive expenditure bracketing, encompassing all contingencies.

2. No formalisation & recording of these at organisational levels into “non-committal” estimates.
3. No provision of an estimation folio to the prospective caretaker as a ready reckoner at the time of the consultancy.
4. The unavailability of a cumulative , time bound (daily if possible) expenditure reminder against the advance deposited.

57. Treating Physician

TREATING PHYSICIAN SERVICES							
	Completely Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Completely Dissatisfied	NA	W. Avg
Rating	5	4	3	2	1	0	
Over all rating of Physician Services	315	35	0	0	0	0	4.9
Explanation of Disease							
(a) By Referring agency	147	35	70	28	70	0	3.46
(b) By treating Surgeon at Gangaram	350	0	0	0	0	0	5
Physician attention during patient recovery	315	35	0	0	0	0	4.9
Explanation of procedures, tests and treatment	315	0	0	35	0	0	4.7
Ability to diagnose problem	350	0	0	0	0	0	5
Thoroughness of examination	350	0	0	0	0	0	5
Skill in treating condition	329	21	0	0	0	0	4.94
Explanation of possibility of negative outcome	266	35	7	0	42	0	4.38
Aftercare followup	266	56	0	0	0	28	4.44
Were anxieties and concerns addressed	308	21	0	21	0	0	4.76
Ease of getting through on phone	259	35	21	0	0	35	4.28

58. Reason for dissatisfaction.The primereasons at this point that could be considered the “trigger” for the cost related dissatisfaction with the caretakers, is the “Explanation of the

disease" by the referring agencies. The following points noted are as given below.

d. The endorsement of a less complex disease & thus a lesser associated expenditure to be borne by the caretakers was held null and void on inspection by the treating physician; and confirmed as a more complicated disease involving larger expenditure.
e. This bolsters the image of a "big-city, big hospital" trying to make money in the mind of the caretakers.
f. Social & peer pressures (i.e. advise of elders 7 relatives/ assurances by doctors not specialising in paediatric & neonatal cardiac surgeries) gain primacy due to this. In due time, when the caretaker reverts to Sir Gangaram Hospital to the surgeon the patient's condition has invariably worsened & the treating physician in unable to hold on to
    viii. The pervious stated line of treatment, or,
    ix. The previous cost estimate due to the change in the line of treatment.
g. This cements the perception of the hospital exploiting the caretaker.

59. Perception management thus can be controlled to a judicious degree by ensuring that an SOP for prior sharing of soft copies of investigative documents over the net (Skype and Google) be looked into. This will require coordinated timing with the doctors from referring satellite clinics, as well as, devising a new appointment calendaring technique for on screen referrals as well.

60. Diagnostic Services

DIAGNOSTIC SERVICES							
	Completely Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Completely Dissatisfied	NA	W. Avg.
Rating	5	4	3	2	1	0	
Over all rating of Diagnostic services	273	49	28	0	0	0	4.7
IV Line insertion	315	35	0	0	0	0	4.9
Removal from Ventilator	231	63	7	0	0	49	4.08
Laboratory Experience	294	28	14	14	0	0	4.72
Speed of test results being made available	315	28	7	0	0	0	4.88

61. Reason for dissatisfaction. NIL.

62. Miscellaneous Points

MISCELLANIOUS POINTS & FACILITY							
	Completely Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Completely Dissatisfied	NA	W. Avg
Rating	5	4	3	2	1	0	
Facilities							
Over all rating of Department and its Facilities	308	42	0	0	0	0	4.88
Ease of Access	280	49	21	0	0	0	4.74
Comfort	308	21	0	21	0	0	4.76
Cleanliness	294	14	0	42	0	0	4.6
Temperature Control	308	21	0	21	0	0	4.76
Equipment	329	21	0	0	0	0	4.94
Miscellaneous Points							
Timelag between diagnosis and procedure	350	0	0	0	0	0	5
Money spent Vs Risk satisfaction	308	21	0	0	21	0	4.7
Ease of seeing a doctor of choice	350	0	0	0	0	0	5
Outcome of care/ how effective was the procedure	259	42	0	49	0	0	4.46
Explanation of cost and expected hospital bill	259	56	0	21	14	0	4.5

63. Reason for dissatisfaction.

a. Here attention is drawn to the “Outcome of Care”. This variable has indicated fifty six (56) in numbers as somewhat dissatisfied. The deductions in the seven cases point out towards these possible gaps.

b. Spill over of estimated expenditure towards the higher side incurs post treatment resentment in caretakers.

c. This is invariably higher in case of those people who make out of pocket expenditures, and, those caretakers where the initial diagnosis has given rise to a misplaced sense of simplicity of the prevalent disease & manageable costs by referring hospitals.

64. Financial Support. The CSR guidelines & the guidelines for provision of financial support to patients embellish the fact that support be provided to a certain category of people (i.e. those whose income is in the BPL class). However, there is a group of General Category of caretakers who are on the borderline for whose this expenditure is catastrophic. These people manage this expense by resorting to extreme steps like, selling their small land holdings and gold. There is a need to approach NGO’s to be able to include these people in their gambit of assistance.

65. There has been a recurrent feedback from a large section of the caretakers appealing for the provision of a CD for the recording of the operations / procedures conducted for record keeping at their end.

CONCLUSIONS

66. Communication with the caretakers.

a. Both verbal and non-verbal communication has ensured a very high degree of satisfaction levels. Further, communication skills with focus on the specified areas need to be to be honed. The feeding protocol and child diet need to be structured and made easier to comprehend and mandatory for the caretaker to undergo as a part and parcel of the programme.

b. A set pattern of communication (with SOPs in place for timings, interactions and remuneration concords) has to be defined with the referring satellite hospitals.

67. Feedback system & practise.

a. The department needs to institutionalise its feedback system. It can be carried out by the non-medical staff after some basic training.

b. The requirement of recording the same in an appropriate, comprehensive, and holistic manner is essential to be able to get clear picture of the impact of the medical effort put in. It has to be able to provide a periodic quantitative & qualitative comment which is both realistic and valid.

68. Conclusion.

a. The primary challenge is to ensure a regular analysis of caretaker satisfaction.

b. A situation exists to undertake a larger and encompassing study for tracking caretakers inside the hospital and discerning how they spend their time & identify possible sources of delay and discontent.

c. Target precise training has to be arranged for enhancing caretaker linkedutilities in areas identified.

Appendix A: Refers to Para 3(a) of Identification of problems

Ser	Variables	Items of Information
1.	Admission & Discharge Services	Overall rating of Admission services
		Staff attention
		Wait time
		Explanation of procedures
		Personality of Admitting Staff
		Information provided on billing process
		Overall rating of Discharge Procedure
		Clear Understanding of bill

Ser	Variables	Items of Information
2.	Treating Physician Services	Overall rating of Physician Services
		Explanation of Disease
		(a) By Referring agency
		(b) By treating Surgeon at Gangaram
		Physician attention during patient recovery
		Explanation of procedures, tests and treatment
		Ability to diagnose problem
		Thouroughness of examination
		Skill in treating condition
		Explanation of possibility of negative outcome
		Aftercare follow up
		Were anxieties and concerns addressed
		Ease of getting through on phone

Ser	Variables	Items of Information
4.	Miscellaneous Points & facilities	Over-all rating of Department and its Facilities
		Ease of Access
		Comfort
		Cleanliness
		Temperature Control
		Equipment
		Miscellaneous Points
		Time lag between diagnosis and procedure
		Money spent Vs Risk satisfaction
		Ease of seeing a doctor of choice
		Outcome of care/ how effective was the procedure
		Explanation of cost and expected hospital bill

Ser	Variables	Items of Information
3.	Diagnostic Services	Over all rating of Diagnostic services
		IV Line insertion
		Removal from Ventilator
		Laboratory Experience
		Speed of test results being made available

LIMITATIONS

1. Demography was limited to the population work group available in the Department
2. Time limitation presented a challenge in
    i. Transcription of data
    ii. Approval by hospital authorities
    iii. Sample size
3. The non-contributory population was defined by the gaps in Secondary Data at the hospital library.

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