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THE ROLE OF INTERNAL QUALITY AUDIT IN ENHANCING HOSPITAL PERFORMANCE AND PATIENT SATISFACTION

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ABSTRACT

Purpose: This study looks at how internal quality audits are used at a multi-speciality hospital in Odisha, and how the practices they monitor connect to what patients and attendants actually experience. It asks two linked questions. First, how well are quality, safety, infection-control and documentation practices being followed across hospital departments? Second, how satisfied are patients with the services they receive, and where do the two views point to the same gaps?

Methodology: The paper is structured as a descriptive and analytical study. For this completed sample draft, the Chapter 6 tables use an illustrative dataset of 40 hypothetical patient/attendant responses and simulated departmental audit scores. These values demonstrate frequency, percentage, mean-score and compliance calculations; they are not actual hospital observations and must be replaced with verified primary data before empirical submission.

Illustrative findings: In the sample dataset, 65% of respondents are satisfied or very satisfied overall, while 45% report satisfaction with waiting time. Doctor behaviour has the highest mean satisfaction score (3.93/5), and waiting time has the lowest (3.13/5). Simulated departmental compliance ranges from 77.8% in Front Office to 90.0% in CSSD; staff awareness and training is the lowest illustrative audit domain at 75.6%. These figures are examples only and are not verified hospital findings.

Implication: The study argues that audit results and patient feedback are most useful when read together. Hospitals can use that combined picture to decide which departments, processes and communication gaps deserve attention first, and to keep improvement work tied to measurable follow-up.

KEYWORDS: Internal quality audit; patient satisfaction; hospital quality; NABH; healthcare management; continuous quality improvement; Odisha.

1. INTRODUCTION

1.1 Quality in Healthcare

Quality in healthcare is about more than having doctors, beds and equipment. What matters is whether care is delivered reliably, safely and in a way that patients can trust. A hospital that has all the right facilities can still fall short if records are incomplete, medicines are not stored properly, or patients are left waiting without explanation. For this reason hospitals need regular, structured ways of checking their own work.

Healthcare is also different from most other services. The patient usually arrives anxious, often with limited knowledge of what is being done and why, and a small lapse such as a wrong label, a missed identification check or an expired medicine can cause serious harm. Because the stakes are high, the sector relies heavily on written procedures, checklists and accreditation standards. Quality management is the discipline that makes sure those written rules are followed in daily practice.

1.2 Internal Quality Audit

An internal quality audit is one of the main tools of that discipline. It compares what is actually happening in a department against what the hospital's policies, procedures and accreditation standards say should happen. The audit is carried out by people from within the organisation, usually the quality team working with department staff, and it is repeated at regular intervals. Done well, it turns scattered observations into a record of where practice is sound and where it has slipped, and it gives the team something concrete to correct.

Internal audits have a few practical strengths. They are inexpensive compared with external assessments, they can be repeated often, and they build familiarity with standards among the staff who are audited. Their limitation is that they examine the hospital from the inside. They show whether a procedure was followed, but not necessarily whether the procedure made the patient's experience better.

1.3 Patient Satisfaction

Patients notice how long they waited, whether the nurse was approachable, whether the doctor explained the treatment, whether the ward was clean and whether the billing desk was helpful. Patient satisfaction captures this outcome-side view. It is not a perfect measure, because it is shaped by expectations, mood and the result of treatment, but it is the only direct measure of how care is experienced by the people it is meant for. Many accreditation systems, including the one followed in India, therefore expect hospitals to collect and act on patient feedback.

1.4 Why the Two Should Be Read Together

Looking at audits and patient feedback together gives a fuller account of hospital quality than either offers alone. An audit may show that hand hygiene compliance is high while patients still complain about cleanliness, which would suggest that the checklist is not capturing what patients see. Equally, patients may be content with a service whose records are poorly kept, which would suggest a hidden risk that satisfaction alone would never reveal. Placing the two side by side helps a quality team find such mismatches, and that is the reason this study combines them.

1.5 Need and Significance of the Study

For a hospital, the practical value lies in prioritisation. Quality teams rarely have the time or resources to fix everything at once. If audit findings and patient comments both point to the same weak spot, that area has a strong claim on attention. For a management student, the study shows how the Donabedian idea of structure, process and outcome plays out inside a working hospital rather than only in a textbook, and it offers hands-on exposure to audit methods, NABH standards and the use of data in decision making.

1.6 Statement of the Problem

The study seeks to assess the extent to which hospital quality and safety practices are being maintained across selected departments through internal quality audit checklists, and to assess patient satisfaction with hospital services, in order to identify quality gaps and suggest areas for improvement.

2. PROFILE OF THE ORGANISATION

The hospital studied is a healthcare service provider located in Odisha; its name is withheld for confidentiality. It was established in 2018 and operates in the healthcare sector as a multi-

speciality hospital. The study was carried out in its Quality Department under the guidance of the Assistant Quality Manager.

Particular	Details
Name of organisation	Healthcare
Sector	Healthcare
Year of establishment	2018
Location	Odisha
Nature of business	Healthcare service provision
Department of internship	Quality Department
Industry mentor	Mr. Binayak Dhal, Assistant Quality Manager

2.1 The Quality Department

The Quality Department is responsible for keeping the hospital's processes aligned with its policies and with accreditation requirements. During the internship period its work included familiarisation with NABH standards and SOP documentation, study of departmental quality indicators, review of internal audit checklists, observation of ICU audit activity, coordination of committee meetings, preparation of circulars, incident documentation, collection of clinical data, and installation and verification of quality, safety and NABH-related signage.

2.2 Departments Covered by Audit Tools

Departmental audit tools were available for the following areas: CSSD, Radiology, Pharmacy, Operation Theatre, Nursing, Management of Medication, ICU, Human Resource, Front Office, Endoscopy, Emergency, Dialysis and Cath Lab. Together they cover clinical, diagnostic, support and administrative functions, which allows the study to look at quality across the hospital rather than in one unit alone.

3. CONCEPTUAL AND THEORETICAL FRAMEWORK

3.1 Donabedian's Structure–Process–Outcome Model

Donabedian (1988) proposed that the quality of care can be judged at three connected levels. Structure refers to the setting in which care is given: buildings, equipment, staffing and policies. Process refers to what is actually done in giving and receiving care: the procedures followed, the records kept, the communication between staff and patients. Outcome refers to the results, including patients' health status and their satisfaction.

The model fits this study well. The audit checklists mainly examine structure and process, for example whether equipment is calibrated, whether consent is documented and whether medicines are stored correctly. The patient satisfaction survey speaks mainly to outcome, in

the sense of how patients judge the care they received. The study therefore uses the model to link what the hospital does with what patients report.

Level	Meaning	Where it appears in this study
Structure	Resources, facilities, equipment, policies	Equipment maintenance and calibration, signage, availability of SOPs, staff awareness
Process	How care and services are actually delivered	Documentation, patient identification, consent, infection-control practices, medication handling
Outcome	Results of care, including patient experience	Patient satisfaction and willingness to recommend the hospital

3.2 SERVQUAL and Perceived Service Quality

Parasuraman, Zeithaml and Berry (1988) described service quality through five dimensions. Tangibles are the physical facilities, equipment and appearance of staff. Reliability is the ability to deliver the promised service dependably. Responsiveness is the willingness to help and provide prompt service. Assurance is the knowledge and courtesy of staff and their ability to inspire trust. Empathy is the caring, individual attention given to the customer.

The questionnaire used here was not designed as a full SERVQUAL instrument, but its items map naturally onto these dimensions, as shown below. This mapping helps in interpreting the survey results without claiming more than the data can support.

SERVQUAL dimension	Related survey items
Tangibles	Cleanliness, facilities, infection control
Reliability	Treatment and medication/follow-up information, administrative services
Responsiveness	Waiting time, nursing responsiveness, staff responsiveness
Assurance	Doctor behaviour, privacy, safety
Empathy	Communication, nursing and doctor behaviour, overall satisfaction

3.3 The Plan–Do–Check–Act Cycle

Continuous quality improvement is commonly described through the Plan–Do–Check–Act (PDCA) cycle. A problem is identified and a change planned, the change is tried, its effect is checked against data, and the change is then either adopted or adjusted. Internal audits sit naturally in the Check stage, and the recommendations of this study are framed so that they can feed the Act stage and then be re-audited.

3.4 NABH Standards

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) publishes standards for hospitals in India. The sixth edition (NABH, 2025) covers areas such as patient

rights, care of patients, medication management, infection prevention, facility management and continuous quality improvement. The audit checklists used in the hospital draw on these themes, which is why NABH standards formed part of the internship learning in the early weeks.

4. LITERATURE REVIEW

The table below summarises the main sources that shaped the study. Each entry notes what the source contributes and why it matters here.

Author / Year	Study / Theme	Contribution	Relevance to present study
Donabedian (1988)	The quality of care: how can it be assessed?	Proposes judging care through structure, process and outcome.	Provides the base for reading audit practice (process) alongside patient-reported results (outcome).
Parasuraman, Zeithaml & Berry (1988)	SERVQUAL	Describes five dimensions of service quality: tangibles, reliability, responsiveness, assurance and empathy.	Guides how patient perceptions of services are grouped and interpreted.
Goyal, Singh & Lukhmana (2017)	Patient perception and satisfaction, OPD, ESIC Medical College, Faridabad	Stresses collecting patients' own views to find service gaps.	Supports the use of a patient survey in a hospital setting.
Sahoo & Sahoo (2019)	Patient satisfaction in OPD services of a government hospital, Odisha	Shows that feedback helps hospitals understand needs and improve delivery.	Gives a regional comparison for an Odisha hospital.
Kaur et al. (2020)	Satisfaction with outpatient and inpatient services, public facilities in a North Indian state	Shows that experiences differ across service settings.	Supports looking at several service areas instead of one overall score.
Quality improvement project (2021)	Patient satisfaction with outpatient services, tertiary teaching hospital, South India	Finds that satisfaction surveys can work as an audit tool to expose service gaps.	Directly supports combining survey results with audit findings.
NABH (2025)	Accreditation Standards for Hospitals, 6th Edition	Sets out the standards against which hospital processes are assessed.	Frames the quality and safety parameters used in the audit checklists.

4.1 Quality Frameworks

Donabedian's model remains the most widely cited starting point for healthcare quality, mainly because it is simple and flexible. It tells a researcher where to look rather than what to conclude. Parasuraman, Zeithaml and Berry's SERVQUAL complements it from the customer side by treating quality as the gap between what service users expect and what they perceive. Between them, the two frameworks justify the central design choice of this paper, which is to study both the delivery of care and its reception.

4.2 Patient Satisfaction Studies in India

Several Indian studies have measured satisfaction in hospital settings. Goyal and colleagues (2017) studied OPD patients at a tertiary-care hospital in Faridabad and argued that patients' perceptions are a prudent basis for assessing and improving services. Sahoo and Sahoo (2019) carried out a cross-sectional study of OPD satisfaction in an Odisha government hospital and reported that feedback can show hospitals where service delivery needs work. Kaur and colleagues (2020) examined both outpatient and inpatient services in public facilities of a North Indian state, which shows that satisfaction needs to be examined across different service settings and not summarised in a single figure.

4.3 Satisfaction Surveys as an Audit Tool

A quality improvement project in a South Indian teaching hospital (2021) treated the patient satisfaction survey itself as an audit tool, using it to identify service gaps in areas such as clinical care, nursing services, physical facilities, cleanliness and medication availability, and to guide corrective measures. This idea is close to the approach taken here, where survey results are placed next to departmental audit findings so that each can help interpret the other.

4.4 Research Gap

The reviewed studies mostly concentrate on patient satisfaction in outpatient settings and on a single type of evidence. Few of them place a hospital's internal audit findings alongside its own patient feedback. This paper attempts that on a small scale within one hospital in Odisha. It does not claim to settle the question, but it shows how a Quality Department can use both sources together.

5. RESEARCH METHODOLOGY

5.1 Objectives of the Study

Primary objective: To assess the role of internal quality audit in monitoring hospital quality practices and to understand how those practices relate to patient satisfaction at a multi-speciality hospital in Odisha.

Secondary objectives are listed below.

- To assess compliance with selected quality, safety, infection-control, documentation and operational practices across departments using internal audit checklists.
- To measure patient and attendant satisfaction with waiting time, doctor and nursing behaviour, communication, cleanliness, facilities, privacy, safety and administrative services.
- To identify the main quality gaps and improvement opportunities that emerge from the audits and patient feedback.
- To recommend practical measures for continuous quality improvement and patient-centred care.

5.2 Research Design

The study is designed as a descriptive and analytical assessment. This working sample version demonstrates the proposed analysis using hypothetical survey responses and simulated audit scores. The final empirical version must use the hospital's authorised departmental audit records and the actual completed patient satisfaction questionnaires. The descriptive analysis summarises responses and compliance, while the analytical discussion compares patient feedback with audit observations.

5.3 Sources of Data

For this sample draft, the numerical dataset in Chapter 6 is illustrative and is not claimed as primary data collected at the hospital. In the final study, primary data should be drawn from authorised departmental internal quality audit checklists, completed patient satisfaction questionnaires, and documented direct observations. Secondary sources may include approved hospital quality records, SOPs, quality-indicator records, published research and accreditation resources.

5.4 The Patient Satisfaction Questionnaire

The questionnaire has two parts. The first collects basic demographic and service information. The second contains satisfaction items covering waiting time, doctor behaviour,

nursing responsiveness, treatment information, medication and follow-up information, cleanliness, facilities, staff responsiveness, privacy, infection control and administrative services, followed by overall satisfaction and willingness to recommend the hospital. Items are answered on a five-point scale from Very satisfied to Very dissatisfied. The full instrument is reproduced in Annexure A.

5.5 The Audit Checklists

Each department has its own checklist, so the items differ. Common themes include patient identification, consent, infection prevention, medication safety, emergency preparedness, equipment maintenance, documentation, staff awareness, quality indicators, housekeeping and patient rights. Department-specific items include investigation turnaround time and radiation safety in Radiology, and medication storage, expiry checks and recall procedures in Pharmacy. A summary of the domains is given in Annexure B.

5.6 Sampling

Element	Description
Sampling technique	Convenience sampling
Sample size	40 usable patient/attendant responses
Sampling unit	Patients and attendants receiving or using hospital services

The worked example uses a hypothetical sample size of 40 and assumes convenience sampling for demonstration. If convenience sampling was actually used, describe the dates, eligibility criteria and recruitment process accurately. A convenience sample may not represent all patients or attendants.

5.7 Tools for Data Analysis

Responses were organised in a spreadsheet and analysed through frequency distribution and percentage analysis. A mean satisfaction score was calculated where applicable by coding Very satisfied as 5 down to Very dissatisfied as 1. Satisfaction across service areas was compared, and departmental audit compliance was calculated as the share of applicable checklist items found compliant. Results are presented through tables and charts.

5.8 Ethical Considerations

For the final empirical study, participation should be voluntary, respondents should not be identifiable in the report, and results should be presented in aggregate. Departmental audit

information should be used only with the hospital's permission. The simulated values in this sample draft do not constitute evidence of consent, data collection or audit access.

5.9 Scope

The study covers quality-management activity during the internship period only. It does not judge the clinical effectiveness of individual doctors or treatments, and it does not compare the hospital with others.

6. DATA ANALYSIS AND INTERPRETATION

ACADEMIC INTEGRITY NOTICE: The numerical values in this completed working draft are illustrative/simulated examples prepared to demonstrate data analysis for a sample of 40. They are not verified findings from the hospital studied and must not be represented as collected hospital data. Before final submission, replace every illustrative survey count and audit score with authorised, actual records and revise the interpretations accordingly.

This section presents the audit and survey results. Percentages are calculated from recorded frequencies out of N = 40 responses.

6.1 Respondent Profile

Category	Frequency	Percentage
Patients	30	75%
Attendants	10	25%
Outpatient (OPD) service users	24	60%
Inpatient (IPD) service users	16	40%
Total (each classification)	40	100%

Note: Respondent type (patient/attendant) and service type (OPD/IPD) are two separate classifications of the same 40 respondents; the categories should not be added together.

6.2 Waiting Time

Response	Frequency	Percentage
Very satisfied	6	15%
Satisfied	12	30%
Neutral	8	20%
Dissatisfied	9	22.5%
Very dissatisfied	5	12.5%
Total	40	100%

Interpretation: In this illustrative dataset, 45% of respondents were satisfied or very satisfied with waiting time, while 35% were dissatisfied or very dissatisfied and 20% were neutral.

The result makes waiting time a comparatively weak service area and suggests reviewing registration, appointment scheduling, patient flow and consultation delays.

6.3 Doctor Behaviour and Treatment Information

Response	Frequency	Percentage
Very satisfied	12	30%
Satisfied	18	45%
Neutral	6	15%
Dissatisfied	3	7.5%
Very dissatisfied	1	2.5%
Total	40	100%

Interpretation: The doctor-behaviour responses show 75% satisfaction (satisfied or very satisfied), 15% neutral responses and 10% dissatisfaction. This indicates a relatively positive view of doctors' behaviour. Treatment explanation is a separate questionnaire item and its illustrative mean is reported in Section 6.9; separate response frequencies should be taken from the original questionnaire records.

6.4 Nursing Responsiveness

Response	Frequency	Percentage
Very satisfied	10	25%
Satisfied	17	42.5%
Neutral	8	20%
Dissatisfied	4	10%
Very dissatisfied	1	2.5%
Total	40	100%

Interpretation: Nursing responsiveness received 67.5% positive responses, compared with 75% for doctor behaviour. The difference suggests that nursing responsiveness may need additional attention, particularly timely assistance, patient monitoring, communication and documentation. These are illustrative results and should be checked against actual responses.

6.5 Medication and Follow-up Information

Response	Frequency	Percentage
Very satisfied	7	17.5%
Satisfied	16	40%
Neutral	9	22.5%
Dissatisfied	6	15%
Very dissatisfied	2	5%
Total	40	100%

6.6 Cleanliness, Facilities and Infection Control

Response	Frequency	Percentage
Very satisfied	9	22.5%
Satisfied	17	42.5%
Neutral	8	20%
Dissatisfied	4	10%
Very dissatisfied	2	5%
Total	40	100%

Interpretation: 65% of respondents were satisfied or very satisfied with the combined cleanliness, facilities and infection-control item, while 15% were dissatisfied and 20% were neutral. The illustrative infection-prevention/housekeeping compliance in Section 6.11 is 83.6%. The difference shows why audit compliance and patient experience should be interpreted together: the audit measures adherence to specified practices, whereas respondents report what they notice.

6.7 Privacy, Staff Responsiveness and Administrative Services

Response	Frequency	Percentage
Very satisfied	8	20%
Satisfied	16	40%
Neutral	9	22.5%
Dissatisfied	5	12.5%
Very dissatisfied	2	5%
Total	40	100%

6.8 Overall Satisfaction and Willingness to Recommend

Overall satisfaction	Frequency	Percentage
Very satisfied	9	22.5%
Satisfied	17	42.5%
Neutral	8	20%
Dissatisfied	4	10%
Very dissatisfied	2	5%
Total	40	100%

Would recommend the hospital?	Frequency	Percentage
Yes	29	72.5%
Not sure	7	17.5%
No	4	10%
Total	40	100%

6.9 Item-wise Mean Satisfaction Scores

To compare service areas on one scale, the mean score for each item is shown below, with Very satisfied coded as 5 and Very dissatisfied as 1.

Service area	Mean score (out of 5)	Rank
Waiting time	3.12	12
Doctor behaviour	3.92	1
Nursing responsiveness	3.77	2
Treatment information	3.70	3
Medication / follow-up information	3.50	10
Cleanliness	3.67	4
Facilities	3.58	8
Staff responsiveness	3.62	6
Privacy	3.52	9
Infection control	3.62	6
Administrative services	3.38	11
Overall satisfaction	3.67	4

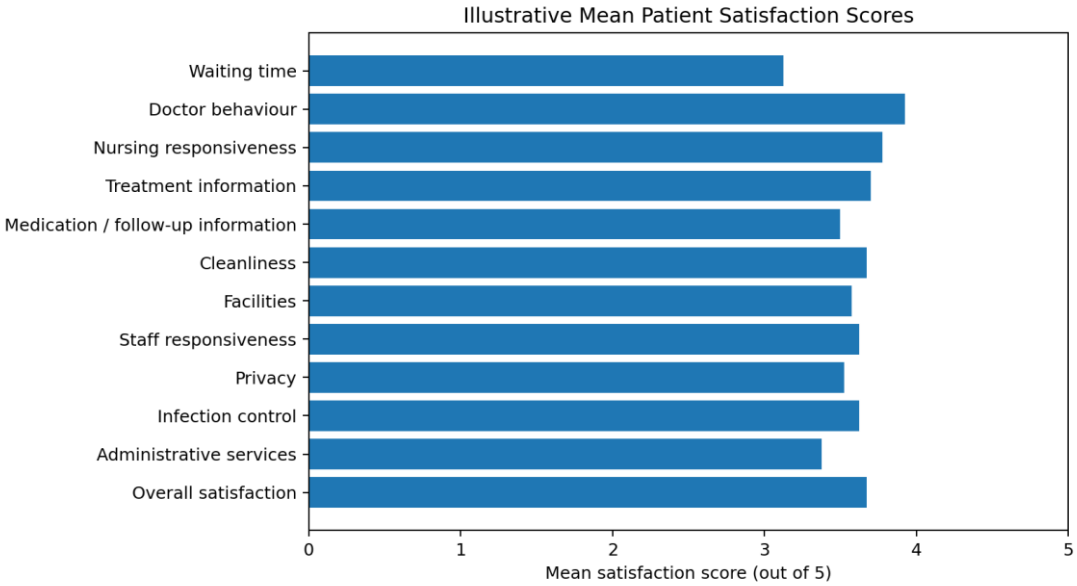

Figure 6.1: Illustrative mean patient satisfaction scores. These scores are hypothetical and require verification against item-level survey data.

Calculation note: The mean scores for individual items such as treatment information, facilities, staff responsiveness, privacy, infection control and administrative services are illustrative item-level values. The combined frequency tables in Sections 6.6 and 6.7 do not provide separate frequencies for each component; actual item-level questionnaire records are required to verify these separate means.

6.10 Departmental Audit Compliance

Each department's checklist was scored as the share of applicable checklist items found compliant. Only departments for which completed audit records were available are included.

Department	Items audited	Items compliant	Compliance %	Main gap noted
CSSD	20	18	90.0%	Incomplete sterilization records
Radiology	18	15	83.3%	Equipment documentation
Pharmacy	22	18	81.8%	Medication storage records
Operation Theatre	24	20	83.3%	Surgical checklist documentation
Nursing	25	21	84.0%	Nursing documentation
Management of Medication	20	16	80.0%	Medication reconciliation
ICU	24	21	87.5%	Monitoring documentation
Human Resource	16	13	81.2%	Staff training records
Front Office	18	14	77.8%	Registration and feedback records
Endoscopy	18	15	83.3%	Procedure documentation
Emergency	22	18	81.8%	Emergency preparedness records
Dialysis	20	17	85.0%	Treatment documentation
Cath Lab	20	17	85.0%	Procedure checklist records

6.11 Compliance by Audit Domain

Audit domain	Departments where applicable	Overall compliance %
Documentation and records	All relevant departments	84.0%
Patient identification and consent	Nursing, ICU, OT, Emergency, Cath Lab and Endoscopy	84.4%
Infection prevention and housekeeping	CSSD, Nursing, ICU, OT, Dialysis and other relevant departments	83.6%
Medication safety	Pharmacy, Nursing, ICU and Medication Management	80.0%
Equipment maintenance and calibration	Radiology, ICU, OT, Dialysis and Cath Lab	83.3%
Emergency preparedness	Emergency, ICU, OT and relevant departments	77.5%
Staff awareness and training	All relevant departments	75.6%
Patient rights	Front Office, Nursing, OPD, IPD and relevant departments	86.7%

6.12 Reading the Audit and Survey Together

Quality area	Audit observation	Patient feedback	Do they agree?
Infection control and cleanliness	83.6% illustrative infection-prevention/housekeeping compliance	65% satisfied with combined cleanliness/facilities/infection-control item	Partially; measures are related but not identical
Medication safety and information	80.0% illustrative medication-safety compliance	57.5% satisfied with medication/follow-up information	Broadly; both indicate scope for improvement
Documentation and patient communication	84.0% illustrative documentation compliance	75% satisfied with doctor behaviour; treatment-information mean 3.70/5	Partially; documentation compliance does not measure clarity of communication directly
Waiting time and front-office process	77.8% illustrative Front Office compliance	45% satisfied with waiting time	Broadly; both suggest an operational improvement priority

This comparison is the heart of the study. Where audit scores are strong and patient views are also positive, the system appears to be working. Where audit scores are strong but patients are dissatisfied, the checklist may be missing something patients care about. Where both are weak, the area is a clear priority. Where audit scores are weak but patients are satisfied, a hidden risk may exist that patient experience alone would not reveal.

7. DISCUSSION

This discussion interprets the illustrative survey and audit results in relation to the study's conceptual framework. Because the numerical values are simulated, the discussion demonstrates an approach to interpretation rather than reporting verified performance at the hospital.

7.1 How to Read the Combined Picture

The combined illustrative results show why audit compliance and patient satisfaction should be reviewed together. Infection-prevention and housekeeping compliance is shown as 83.6%, while 65% of respondents are satisfied with the combined cleanliness, facilities and infection-control item. Medication-safety compliance is 80%, compared with 57.5% satisfaction with medication and follow-up information. These measures are related but not equivalent: an audit checks defined procedures, whereas a patient survey captures the experience and information received. The comparison therefore identifies questions for follow-up rather than proving a direct causal relationship.

7.2 Linking Results to Donabedian's Model

The Donabedian framework helps organise the evidence. Departmental audit scores mainly describe structure and process, including equipment readiness, documentation, consent, infection prevention and medication handling. Patient satisfaction reflects the outcome-side experience. In this illustrative dataset, the relatively high doctor-behaviour mean (3.93/5) sits alongside weaker waiting-time satisfaction (45% positive). This reinforces that good clinical interaction and efficient service processes are distinct dimensions of quality.

7.3 Linking Results to SERVQUAL

The SERVQUAL dimensions provide another way to interpret the survey. Doctor behaviour (mean 3.93/5) and nursing responsiveness (3.78/5) are comparatively strong in the illustrative results. Waiting time (3.13/5) and administrative services (3.38/5) are weaker, pointing to responsiveness and reliability as improvement priorities. Cleanliness and facilities relate to

tangibles, while privacy and communication relate to assurance and empathy. These groupings are interpretive and do not constitute a full SERVQUAL assessment.

7.4 Comparison with Earlier Studies

The literature reviewed in this paper supports the use of patient feedback as one source of evidence for service improvement. The studies by Goyal et al. (2017), Sahoo and Sahoo (2019), and Kaur et al. (2020) provide relevant Indian hospital contexts for examining patient experience. However, the present numerical example is simulated and cannot be compared empirically with those studies. Once actual data are inserted, comparisons should be limited to broadly similar service dimensions and should acknowledge differences in setting, sampling and questionnaire design.

7.5 Cautions in Interpretation

Neutral responses should not automatically be treated as satisfaction; they may reflect uncertainty, mixed experiences or reluctance to criticise. A small convenience sample may also be affected by selection and response bias. In addition, the simulated sample in this draft is not evidence of actual patient opinion. Any final interpretation must be based on genuine, authorised responses and should not be generalised beyond the study setting without appropriate sampling.

8. MAJOR FINDINGS

The following major findings are based only on the illustrative dataset in Chapter 6 and must be replaced or confirmed using actual records before final submission.

1. Overall satisfaction: 65% of the illustrative respondents were satisfied or very satisfied with the hospital, and 72.5% said they would recommend it.
2. Highest-rated service: Doctor behaviour received the highest illustrative mean score of 3.93 out of 5, with 75% positive responses.
3. Lowest-rated service: Waiting time received the lowest mean score (3.13/5); only 45% of respondents were satisfied or very satisfied.
4. Nursing responsiveness: 67.5% of respondents gave a positive rating, with a mean score of 3.78/5.
5. Departmental compliance: CSSD had the highest simulated compliance (90.0%), while Front Office had the lowest (77.8%).
6. Audit-domain compliance: Patient rights had the highest illustrative compliance (86.7%), while staff awareness and training had the lowest (75.6%).

7. Medication-related experience: 57.5% of respondents were satisfied with medication and follow-up information, compared with simulated medication-safety compliance of 80.0%.
8. Combined cleanliness and infection-control feedback: 65% of respondents were satisfied or very satisfied, while the related simulated audit-domain compliance was 83.6%.
9. The comparison suggests that procedural compliance alone does not fully describe patients' experience; communication, waiting time and accessibility should also be monitored.
10. The figures demonstrate how internal audits and patient feedback can be combined to identify improvement priorities, but they do not establish a causal effect of audits on satisfaction.

- Share of respondents overall satisfied with the hospital, and share willing to recommend it.
- Best-rated and lowest-rated service area on the survey, with percentages and mean scores.
- Department with the highest audit compliance and the department with the lowest.
- Audit domain with the weakest compliance across departments.
- One area where audit results and patient feedback agree, and one where they differ.
- Any documentation or record-keeping gap that appeared repeatedly.
- Any difference between outpatient and inpatient responses, if the data allow.

9. SUGGESTIONS AND ACTION PLAN

The points below are general directions that follow from the structure of the audit tools and the survey. Keep the ones your data supports and drop the rest.

9.1 General Suggestions

- Close the loop on audit findings. Give each gap a named owner, a deadline and a re-audit date so that findings lead to visible correction.
- Review high-risk areas more often, especially medication management, infection control, ICU and emergency preparedness, where lapses carry greater patient risk.
- Look at the patient journey from registration to billing, and set a simple waiting-time target for the busiest points.
- Train staff on communication: explaining treatment, medicines and follow-up in plain language, and protecting privacy.

- Make patient feedback routine. A short survey at discharge, reviewed monthly alongside audit results, would keep both views current.
- Keep audit records complete and consistent across departments so that compliance can be compared and tracked over time.
- Share results with department in-charges in a constructive way, so that audits are seen as support for improvement rather than fault-finding.
- Use visible signage and display boards to remind staff and patients of safety practices and patient rights.

9.2 Suggested Action Plan Using the PDCA Cycle

Stage	Action	Responsibility	Timeframe
Plan	Rank gaps from the audit and survey; set a target for each priority gap	Quality Department with department in-charges	Month 1
Do	Introduce the corrective action: training, process change, display or maintenance	Department in-charges and staff	Months 1–2
Check	Re-audit the department and repeat the relevant survey items	Quality Department	Month 3
Act	Standardise what worked; revise the checklist or SOP; set the next target	Quality Manager and committee	Month 3 onward

9.3 Indicators to Track

Indicator	Why it matters
Audit compliance % by department	Shows whether process quality is improving over time
Number of open corrective actions and days to closure	Shows whether findings are being acted on
Patient overall satisfaction % and mean score	Tracks the outcome-side view
Willingness to recommend %	A simple loyalty indicator
Average waiting time at registration, OPD and billing	Addresses a common source of dissatisfaction
Incident and near-miss reports per month	Shows reporting culture and safety awareness

10. LIMITATIONS, SCOPE FOR FUTURE RESEARCH AND CONCLUSION

10.1 Limitations

- The study is limited to a single hospital, so findings may not apply to other healthcare organisations.
- Satisfaction responses are self-reported and can be shaped by individual expectations and personal experience.
- The sample is small (40 responses) and drawn by convenience, so it may not represent all patients.

- The study period matches the internship and cannot capture long-term change in quality performance.
- Audit findings depend on the availability and completeness of departmental records and may not reflect every quality activity in the hospital.

10.2 Scope for Future Research

- A larger and randomly selected sample, drawn separately from outpatient and inpatient services.
- Repeated audit cycles at the same hospital, to see whether corrective actions change results.
- Statistical testing of the link between department-level compliance and satisfaction, if enough data are collected.
- Inclusion of staff views on how audits are carried out and followed up.
- A comparison of several hospitals, which this study did not attempt.

10.3 CONCLUSION

This study is designed to examine hospital quality from two complementary perspectives: internal audit evidence about the implementation of policies and procedures, and patient feedback about the services received. In the illustrative dataset, overall satisfaction is 65%, willingness to recommend is 72.5%, and waiting time is the weakest-rated service area with a mean of 3.13/5. Simulated audit compliance ranges from 77.8% in Front Office to 90.0% in CSSD, while staff awareness and training is the lowest audit domain at 75.6%. These figures are examples only and cannot be treated as actual findings of the hospital studied. Once verified hospital data are inserted, the combined analysis can help management prioritise corrective actions. Internal audits provide a structured method of checking processes, while patient feedback indicates how those processes are experienced. Used together, and followed by assigned responsibilities, deadlines and re-audits, they can support continuous quality improvement.

For the intern, the project also showed that quality work is mostly steady and ordinary: reading checklists, comparing practice with standards, chasing missing records and talking with staff and patients. Its value comes from repetition and follow-through, and that is the lesson this study hopes to pass on to the Quality Department and to other students of hospital management.

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