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**Quality of Healthcare Services at Al-Shifa Medical
Complex in the Gaza Strip**

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School of Public Health



Thesis Approval



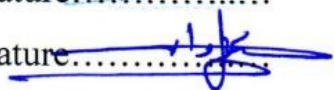
**Quality of Healthcare Services at Al-Shifa Medical Complex in the
Gaza Strip**

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Jerusalem- Palestine

1444 / 2022

Dedication

I dedicate this project to Allah Almighty, my creator, my strong pillar, and my source of inspiration, wisdom, knowledge, and understanding.

I am so grateful to my amazing mother and father, without whom I would not be the person I am today. Thank you for being amazing role models, for always encouraging my dreams, and for all of the sacrifices you made for me to live the life I have.

To my beloved wife, Roaa appreciates the sacrifices you have and I thank you with all my heart for making it possible to help me realize my dream.

To my sons, Seraj, Abd al-Rahman, and Zein, and my beloved girl, Latin. They stood with me and helped me throughout my studies.

To my brothers and sisters, Majed, Magdy, Osama, Mohammed, Hossam, Amani, and Tahani, thank you for being my cheerleaders and for showing patience and tolerance with my busy schedule.

To the souls of martyrs

To my homeland Palestine

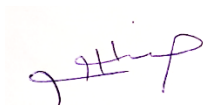
All of them I dedicate this work.

Khalid Ishaq Abd Alqader Al Salty

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any of its parts) has not been submitted for higher degree to any other university or institution.

Signed :

A handwritten signature in purple ink, appearing to read 'Khalid', is written over a light pink rectangular background.

Khalid Ishaq Abd Alqader Al Salty

Date : 17/12 /2022

Abstract

The basis of hospital performance is professional competence in scientific knowledge application methods, modern technologies, and available capabilities. Also, the performance assessment of medical services offers a basis for rational decision-making and service improvement. Moreover, assessment of the clinical quality of care poses several conceptual and practical challenges. It requires a strong evidence base, that can act as a benchmark against which to evaluate interventions. The study aimed to assess the quality of health care services provided at Al-Shifa Medical Complex in the Gaza Strip in medical and surgical departments. The design of this study is triangulated (Quantitative and Qualitative) to assess the quality of healthcare services provided at medical and surgical departments at Al-Shifa Medical Complex using WHO PATH (World Health Organization performance assessment tool for hospitals'). The sample was selected using a probability-stratified random sample. The sample consisted of four strata: the first stratum was consisted of inpatients from medical and surgical departments with different diagnosis who had been discharged during the study period; the second stratum consisted of health care providers (physicians and nurses); the third included database records and hospital statistics and reports; and the final one consisted of four key managers in the Al-Shifa Medical Complex. The total number of inpatients sampled was 175 and the sample for healthcare providers consisted of 220 participants. The study adopted the PATH TOOL, which is used by many European countries to measure hospital performance. Also, the researcher used a self-reported structured interview to collect data from healthcare providers and a structured interview questionnaire to collect data from inpatients at Al Shifa Medical Complex. In addition, database information and reports were analyzed and in-depth individual interviews with the four key managers were done. The study participants' response rate was 100%. The results of this study revealed that the mean percentages for inpatients' perceptions of the quality of healthcare services at the Al-Shifa medical complex ranged from 81.6% to 89.4%. The results indicated that there is a high perception among patients about the services provided at Al-Shifa Medical Complex. Also, the highest perception was in the domains of privacy and respect, while the lowest perception was in the care approach domain.

Furthermore, the results of this study revealed that the mean percentages among healthcare provider perception of the quality of healthcare services ranged from 57.2% and 62%, indicating that healthcare providers' perception of healthcare services provided at Al Shifa medical Complex was moderate. The highest perception for healthcare providers was in the staff orientation and safety domain, and the lowest perception was in the responsive governance domain. In addition, the database indicators, which were obtained from the computerized system and the reports of Al-Shifa Medical Complex, showed that the mortality rate for patients admitted to the hospital in 2020 was 10.6/1000 in the surgical departments and 71.4/1000 in the medical departments, while in the year 2021 the mortality rate in the surgical departments was 9.5/1000 and 86.3/1000 in the medical departments. Furthermore, the indicator of the length of stay (LOS) in the surgical departments in 2020 was 16.76 days, and 5.87 days in the medical departments. While in 2021, LOS was 14.29 days for surgical departments and 7.93 days for medical departments. The readmission rate to hospitals in 2021 during the 30 days following discharge was 7.62 %. The absenteeism rate in the nursing category was about 1.46 percent of the number of working days during the year 2021, and the percentage of absenteeism from the total number of nursing staff was 17.5%.

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List of Abbreviations

ANOVA	Analysis of Variance
DEA	Data Envelopment Analysis
EGH	European Gaza Hospital
HCP	Health Care Provider
HCWs	Health Care Workers
ICU	Intensive Care Unit
IT	Information Technology
GS	Gaza Strip
HSMR	Hospital Standardized Mortality Ratio
LMICs	Low- and Middle-Income Countries
LOS	Length of Stay
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
NGO's	Non-Governmental Organizations
OECD	Organization for Economic Co-operation and Development
OQA	Organizational Quality Assurance Program
PCBS	Palestinian Central Bureau of Statistics
PATH	Performance Assessment Tool for Quality of Hospital
PHC	Primary Health Care
QI	Quality Indicator
SDGs	Sustainable Development Goals
SHMC	Shifa Medical Complex
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the near East
UHC	Universal Health Coverage
WHO	World Health Organization

Chapter One

Introduction

1.1 Research background

All people in the world should have access to high-quality healthcare services regardless of their stage of life or health condition, according to the World Health Organization (WHO, 2018a). Quality in health care does not come easily; it requires effort and should be an important focus of universal health coverage, along with access, coverage, and financial security. Hospitals must first assess their performance before they can improve it. Performance assessment should encourage thoughtful questions, improved data collection methods, understanding of results, and identify actions for improvement. The performance of healthcare delivery systems is of critical importance to policymakers (Ahluwalia et al., 2017). Quality necessitates measurement and the gathering of data because health care is always changing and quality must be continuously evaluated and analyzed to promote progress (WHO-OECD-World Bank-1, 2018).

The core issue of hospital performance is based on professional competencies in the application of present knowledge, available technologies, and resources. Also, it relies on efficiency in the use of resources, minimal risk to the patient, responsiveness to the patient, and optimal contribution to health outcomes. The World Health Organization (WHO) strategic directions are divided into six interrelated dimensions: clinical effectiveness, safety, patient-centeredness, responsive governance, staff orientation, and efficiency. The WHO Regional Office for Europe began a project to create and disseminate a flexible and comprehensive tool for assessing hospital performance, known as the performance assessment tool for quality improvement in hospitals (PATH). This initiative intends to assist hospitals in measuring their performance, questioning their results, and turning them into actions for improvement by providing hospitals with performance evaluation tools and facilitating collegial assistance and networking among participating institutions (Mesarić et al., 2007). In this study, the researcher used PATH TOOL to assess the quality of services provided at Al Shifa Medical Complex (SHMC). Also, areas of strengths and weaknesses in the quality of services provided, in addition, provided recommendations that might help in enhancing the quality of services provided at SHMC.

1.2 Research problem

Palestinian living conditions can make it more difficult for them to get quality health care when they need it, which makes the health care system's shortcomings even more pronounced. Despite some previous difficulties, the Ministry of Health in Gaza has shown notable progress in enhancing the employees' abilities and skills to improve healthcare system development. The Al Shifa Medical Complex is an excellent example of how a healthcare institution should be able to adjust to changing conditions. Some of the challenges facing quality health care services include the standards by which these services are judged, the lack of policies that could help to improve them, and the lack of a clear plan for achieving these goals. The SHMC is highly respected for its excellent clinical performance, but the commitment to quality is not clear. The first stage of hospital services is plagued by process weaknesses, which means that patients are not getting the best possible care. The process of providing hospital services has many weaknesses at the early stages, due to a lack of process strength. Most Palestinian hospitals have a variably implemented operational system that does not have a uniform definition of all processes, whether administrative or technical, and the staff relies on their professional knowledge (Al-Adham, 2004). The most important issue in hospital management today is the need to respond to the rapidly changing global health system by implementing new organizational methods. By using a quality management system, such as the proposed system presented in this study, managers can manage uncertainty, complexity, and speed. The researcher would ascertain whether the work had been invested in and to what extent the services provided at SHMC met the quality standard and whether the community benefited. The study fills a gap in the judgment of the SHMC's performance. It answers an important question: does the quality of services provided at the SHMC meet international standards?

1.3 Justification of study

Quality assessment of health care has become increasingly important for a variety of stakeholders, including health care providers, decision-makers, and purchasers of health care, in response to mounting demands to ensure transparency, control costs, and reduce variations in clinical practice. Few studies explored different domains of quality assessment but there is a lack of studies in evaluating the overall performance in a comprehensive manner using international performance standards. This study is considered as the first study

addressing overall performance assessment and its aim to develop quality indicators for ongoing work, for more standardization and to be used as a tool for continuous monitoring

The SHMC is a major governmental medical complex in the Gaza Strip, and it is considered to be a model for using the latest technologies and innovations. We need to understand how it functions and the challenges it faces that affect its ability to provide quality care. A comprehensive assessment of SHMC revealed strengths and weaknesses in the quality of services provided by the system.

This information can be used to help improve SHMC by developing policies and strategies. This study is the first to focus on the overall performance assessment at SHMC in work and the development of quality indicators to help standardize and continually monitor it

1.4 Aim of the study

The overall aim of this study is to assess the quality of health care services at Al Shifa Medical Complex in the Gaza Strip with a vision to improve the services provided to beneficiaries thus contributing to improving their health status.

1.5 Objectives

- To assess the quality of healthcare services provided at Al Shifa Medical Complex based on modified WHO PATH.
- To assess patients and healthcare providers' perceptions of the quality of Al Shifa Medical Complex services.
- To identify the relationship between socio-demographic characteristics and healthcare providers' perceptions about the quality of health care services provided at Al Shifa Medical Complex.
- To identify areas of strength and weaknesses in the quality of services provided concerning WHO quality performance indicators.
- To provide recommendations that might help enhance the quality of services provided at Al Shifa Medical Complex.

1.6 Research questions

1. How does Al Shifa Medical Complex match the modified WHO PATH guidelines in the quality of services?
2. What perceptions do patients and healthcare providers hold about the quality of Al Shifa Medical Complex services?
3. What is the relationship between the socio-demographic characteristics and healthcare providers' perceptions about the quality of services provided at Al Shifa Medical Complex?
4. What are the strengths and weaknesses in the quality of services provided concerning WHO quality performance indicators at Al Shifa Medical Complex?
5. What recommendations might help enhance the quality of services provided at Al Shifa Medical Complex?

1.7 Context of the study

The study assessed the quality of healthcare services at Al Shifa Medical Complex. The study is conducted in Gaza-Strip-Palestine and could be influenced by this area's geographic, educational, socio-economic, and political situation. Therefore, it is necessary to provide relevant information about the study context as follows.

1.7.1 Geographical and demographic situation

The Gaza Strip is a small strip of land located in the south of Palestine, on the coast of the Mediterranean Sea. It is part of the Palestinian territory and constitutes the coastal zone of that territory. The length of the border is 45 kilometers and its width is 6-12 kilometers. The border's total area is 365 square kilometers. Currently, the Gaza Strip is divided into five governorates: North Gaza, Gaza City, Mid Zone, Khan Younis, and Rafah. In Mid-2022, the estimated population of the West Bank was 3.19million (1.62million males and 1.57million females). While the estimated population of Gaza Strip was 2.17million in the same year (1.10million males and 1.07million females) 64.8% were refugees who lived in the Gaza Strip with a population density of 4,429 persons per km². The percentage of individuals aged (0-14) years constituted 38% of the total population in mid-2022; of whom 36% in the West Bank and 41% in Gaza Strip. The percentage of elderly population aged (65 years and above) reached 3% of the total population; of whom 4% in the West Bank and 3% in Gaza Strip in mid-2022 (PCBS, 2022a).

1.7.2 Socio-economic situation

The Gaza Strip is one of the most densely populated places in the world. An area of less than 365 square kilometres is home to close to 2.17 million (1.10 million males and 1.07 million females), i.e., a population density of about 4,500 per square kilometre. It also has one of the world's highest population growth rates, at more than 43.5 per 1,000 people (PCBS, 2022b). Gaza's economy is largely made up of a small and fragmented industrial sector, whose share of total output varies between 6% and 12%, a very large service sector, which accounts for 45-60% of total output, a large but fluctuating agricultural sector, which accounts for 20-35 percent of total output, and a smaller construction sector, which accounts for 18% of total output. Almost all Gaza businesses rely on imported raw materials and other supplies, which must travel via the Strip's tightly guarded border crossings with Israel, a practice that has harmed the economy over time. With the present shutdown of the borders, the economy is on the verge of permanent collapse, potentially leading to a long-term reliance on humanitarian aid. In 2021 data showed that illiteracy rate among individuals (15 years and above) was 2.3%. The illiteracy gap is significantly noticed among males and females with percentages of 1.2% and 3.5%, respectively. Data also indicated that the percentage of individuals (aged 15 years and above), who have completed university education (bachelor degree and above) was 17% (16% for males and 19% for females) while the percentage of individuals who didn't complete any stage of education reached 7% (6% for males and 9% for females). Also, more than one-fourth of the participants in the labour force were unemployed in 2021, where the percentage reached 26% (16% in the West Bank and 47% in Gaza Strip). Accordingly, unemployment rate reached 43% among females compared to 22% among males. During the first quarter of 2022, around 91% of households stated that they have access to internet service at home or one of their household members has access to the internet (91% in the West Bank and 90% in Gaza Strip). Meanwhile, the percentage of individuals (10 years and above) who used the internet from anywhere reached 88% in Palestine (91% in the West Bank and 83% in Gaza Strip) with no differences on the level of sex (PCBS, 2022c).

1.7.3 The health care context

The health system in the Palestinian territories occupied by Israel since 1967 is not well-coordinated or well-funded. The Gaza Strip has been subject to a blockade since 2007, which has led to the neglect of its health sector. Emergency humanitarian interventions have taken

precedence over long-term development projects, in successive escalations. In 2012, the United Nations warned that Gaza would become uninhabitable unless socioeconomic trends changed. Since that time, socioeconomic indicators have worsened, including indicators for healthcare. The improvement in the health conditions in Palestine has been a major contributing factor to the increase in life expectancy. The decrease in deaths from maternal causes has led to an increase in life expectancy overall. The life expectancy at birth has increased in Palestine due to improvement in the health conditions, and gradual decline of infant, child, and maternal mortality rates. In 2021, the life expectancy rate at Birth was 74.2 years, for males and females were 73.1 years, 75.3 years, respectively (MOH, 2022a).

The decrease in communicable disease incidence, longer life expectancy, and changes in lifestyle have affected the morbidity profiles of refugees. Non-communicable diseases, such as cardiovascular diseases, chronic respiratory diseases, diabetes mellitus, and cancer, are becoming increasingly common concerns (UNRWA, 2017a). The Palestinian health-care system is comprised of four main healthcare providers: the Ministry of Health (MOH), the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), non-governmental organizations (NGOs), and the private profit sector.

The Ministry of Health provides primary, secondary, and tertiary health services and purchases tertiary health services from local and international suppliers when they are unavailable. The UNRWA offer preventive and curative health services to sustain and promote the health of Palestine refugees, from conception through pregnancy, childhood, adolescence and adulthood and active ageing. These services include family planning, pre-conception care, antenatal care and postnatal follow-up, infant care (growth monitoring, medical check-ups and immunizations), school health, oral health, outpatient consultations, diagnostic or laboratory services and the management of chronic non-communicable diseases (UNRWA, 2021a). Non-governmental organizations (NGOs) offer primary, secondary, and tertiary services also, play an important role in rehabilitation. All three levels of care are provided by the private, for-profit sector through various specialized hospitals and investigation centers. MoH is the largest employer of human resources working in the health sector in Palestine. In 2021, the total number of employees in the Palestinian MoH was 19,342 employees (MOH, 2022b). An analysis of the MOH human resource profiles over the previous decade reveals considerable fluctuations in overall employment and critical human resource distribution, demonstrating the effect of numerous ad hoc variables

rather than a deliberate program for human resource growth. Overall, the ratios of health professionals to the population imply that the overall supply of health professional categories in the Occupied Palestinian Territory is good.

The physician-to-population ratio was 14.9/10,000 in 2021; it was 19.0/10,000 in the West Bank and 8.9/10,000 in the Gaza Strip. Significant increases were also observed in the ratios of dentists, pharmacists and nurses to the population. The MOH, NGOs, UNRWA, and the private sector are the four health providers who offer primary health care (PHC). The number of PHC centers in Palestine in 2021 was 756. The Ministry of Health (MOH) operates most PHC facilities (491 centers): 439 centers in the West Bank and 52 centers in the Gaza Strip, with one center per 4,647 people in the West Bank and one center per 13,250 people in the Gaza Strip.

From MOH data in 2021, there were 89 hospitals in Palestine. The number of hospital beds in Palestine (including psychiatric and neurological hospitals) is 7,769 beds, with rates of 14.9 beds per 10,000 population and 1.7 hospital per 100,000 population. In Gaza Strip, there are 35 hospitals with a total number of hospital beds (including psychiatric and neurological hospitals) was 3,587 beds, with rates of 16.8 beds for 10,000 of population and 1.6 hospitals for 100,000 population. The number of MoH hospitals in Gaza Strip is 13 hospitals with 2,824 beds (MOH, 2022c).

There are only many hospitals in the Gaza Strip that can handle major trauma cases: Al Shifa Medical Complex in Gaza City, the Indonesian Hospital in the North Governorate, Al-Aqsa Hospital in the Middle Governorate, Nasser Medical Complex, and Gaza European Hospital in the Southern Governorate of the Gaza Strip.

1.7.4 Al-Shifa medical complex (SHMC)

The Al-Shifa medical complex, located in Gaza City's Al-Rimal district, was founded in 1946. Since 1946, the Al-Shifa medical complex has grown several times in 2016. Nowadays, the total clinical capacity has 496 inpatient beds on a total area of 42,000 m², with a flat existing building area of 15,235 m², consisting of several buildings of several floors, and serves the Gaza Strip residents who have faced many abrupt wars in the past ten years. The total number of employees in all specialties is 1916 (MOH, 2021a). The Al Shifa Medical Complex is the largest and biggest public medical complex in the Gaza Strip (GS).

It has a capacity of 710 beds, divided between 241 daycare beds and 496 inpatient beds. The complex comprises three main hospitals: a surgery hospital with 15 departments, internal medicine with 6 departments, and a maternity hospital with 7 departments, in addition to 5 departments of ICU (MOH, 2021b). Intensive care departments are distributed as follows; medical and surgical intensive care units, coronary intensive care unit, cardiac surgery intensive care unit and burn intensive care unit. The complex contains four main internal departments: internal departments for men and women, departments of general surgery, a department of birth, a department of children and nursery, and emergency departments: (medical and surgical). Also, Al-Shifa Medical Complex contains a department of diagnostic, and therapeutic catheters and is equipped with all the needs that reduce the transfer of patients to other hospitals, during the year 2021, the Cath department conducted 1,409 exploratory catheters for patients, as well as 574 therapeutic catheters, 5 peripheral catheterization cases, 3 cases of cardiac binoculars, in addition to 11 cases of implantation of a pacemaker device. Additionally, Al-Shifa Medical Complex owns a department of cardiac surgery and performs many related operations.

Al-Shifa Medical Complex began the issue of kidney transplantation years ago, and it conducts many kidney transplantation operations with the help of specialized foreign delegations, which in turn train local staff within the complex to reach dependence on them in the future in transplantation operations without external assistance. The Al-Shifa Medical Complex transplanted kidneys for 17 cases in 2021 and all of them were successful operations, according to the annual reports of the complex 2021.

There are three operating theatres at the complex; besides general surgery, there are three specialist operation units: bones and urology and ear, nose, and throat surgery additionally to gastrointestinal endoscopes, bronchoscopes. The hospital has an X-ray department, a laboratory and blood bank, physiotherapy, an audiogram, tissue testing, a pharmacy, an engineering unit, and maintenance. There are other specialist clinics at the hospital, including an internal medicine clinic, a surgical clinic, a women's clinic, and delivery clinic, an ear, nose, and throat clinic, an orthopedic clinic, a kidney and urinary tract clinic, a rheumatic disease clinic, and a dermatology clinic (Al-Najar et al., 2018). According to Al-Shifa Medical Complex's annual report for 2021, the surgical emergency department at Al-Shifa Medical Complex served 152,231 patients, while the internal medicine emergency department served 86,709 patients. Additionally, 60,160 patients visited Al-Shifa Medical

Complex's outpatient clinics in 2021. In 2021, there were 35,140 admissions to the departments of the Al-Shifa Medical Complex. These patients arrived through the reception and emergency departments, while 7,676 general patients came through the outpatient clinics.

1.8 Operational definitions

Clinical Indicators: Clinical indicators indicate the quality of the patient care delivered. They must comply with high-quality standards and be constructed carefully and transparently (Wollersheim et al., 2007).

Quality of Care: quality is something that must be pursued. It will not happen by itself. It must be planned, strategies and activities implemented, and scientific methods used. It necessitates advanced learning and adequate training, and skilled leaders must carry it out through consensus building and teamwork. It will only be achieved if an effective selection process is used when selecting the best implementation strategy—decisions are made as informed decisions (WHO, 2004).

In addition to these definitions, quality of care is defined as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes." In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centered (Healthy Newborn Network, 2017).

Clinical effectiveness: The World Health Organization definition refers to a hospital's success in producing clinical outcomes based on current medical knowledge and achieving these results for all patients who may benefit from them. This includes adherence to and outcomes of care processes as well as the appropriateness of care (WHO, 2007).

Efficiency: The World Health Organization defined efficiency as the optimal use of resources to achieve maximum output, including productivity, health technologies to provide the best possible care, and the appropriateness of interventions (WHO, 2007).

Staff orientation: According to the WHO, it refers to the degree to which employees are qualified, have the opportunity for continuous learning, work in a supportive environment, and are satisfied with their jobs. This dimension includes workplace indicators, employee

prospects, and the identification of individual needs. Health promotion and safety initiatives, as well as staff health-related behavior and health status, are also included (WHO, 2007).

Responsive governance: The WHO definition encompasses the hospital's relationship to community health needs, ensuring continuity of care and providing health services regardless of ethnic group, physical, cultural, social, demographic, or economic characteristics. The hospital's community involvement and public-health orientation (WHO, 2007).

Safety: The WHO definition of safety is linked to implementing and promoting structures and processes in hospitals where evidence demonstrates risk prevention or reduction. Safety includes not only patient safety but also staff and environmental safety (WHO, 2007).

Patient-centeredness: The WHO defined patient-centeredness as placing the patient at the center of service delivery and evaluating services provided concerning the needs and expectations of patients, families, and caregivers. Client orientation (prompt attention, access to supportive networks, communication processes) and respect are examples of this (patient autonomy, confidentiality, and dignity)(WHO, 2007).

Chapter Two

Conceptual Framework and Literature Review

2.1 Conceptual framework



Figure (2.1): Conceptual framework of the study “self-development” adapted from WHO PATH TOOL

The researcher has compiled a comprehensive framework to address the key issues surrounding quality in healthcare services after reviewing the available literature on the topic. The researcher has found that the WHO PAHT recommends six aspects. The WHO Quality Assessment Tool for Hospitals is a comprehensive tool that used to measure hospital quality in Europe. The project has been successfully trialed at several hospitals in Europe,

with a high response rate. This assessment will focus on the clinical effectiveness, efficiency, staff orientation, responsive governance, safety, and patient-centeredness of the hospital.

The first dimension is clinical effectiveness, measured through facility infrastructure and work environment, return to ICU, prophylactic antibiotic availability and use total mortality rate, and readmission rate.

The second dimension is efficiency, measured through the length of stay.

The third and fourth dimensions are staff orientation and safety, measured through work-related injuries by type, training, workload, excessive working hours, and absenteeism of workers.

The fifth dimension is responsive governance, measured through management's stand on the worker's psychological, economic, and social conditions, availability of medication, and medical supplies.

The sixth dimension of the theoretical framework is patient-centeredness, and it is measured through overall expectations and patients' perceptions of health care services provided, and specific domains of self-interviewed questionnaires.

2.1.1 Clinical effectiveness

Clinical effectiveness is the extent to which specific clinical interventions do what they are intended to do in the field for a specific patient or population—that is, maintain and improve health and secure the most significant possible health gain from the available resources (Chambers, 2001). In another way, clinical effectiveness is a broad term that encompasses a variety of actions that aid clinicians and healthcare workers in assessing and improving the quality of care they provide. Clinical effectiveness is defined by the Department of Health (1996) as the application of the best knowledge derived from research, clinical experience, and patient preferences to achieve the best processes and outcomes of care for patients. "The procedure includes a framework for informing, changing, and monitoring practice" (NHS, 2018). Clinical effectiveness is a quality improvement approach that promotes cost-effective healthcare that is evidence-based, to subsequently improve clinical decision-making and clinical outcomes. Furthermore, it is defined as applying the best knowledge derived from research, clinical experience, and patient preferences to achieve optimal patient care

processes and outcomes. Clinical effectiveness is a set of activities and tools based on research and measurement that are used to improve healthcare quality. Guidelines, audits, research, and evaluation are just a few of the activities (National Patient Safety Office, 2018).

When care is ineffective, i.e., when clinicians do not follow evidence-based standards, this may represent a lack of awareness of the rules or a lack of compliance regardless of knowledge. The effectiveness of care can be evaluated in a variety of ways, including review of medical records, patient exit interviews, direct observation of provider-client interactions, standardized patients, or clinical vignettes (WHO, 2018a).

Also, the organizations must change the actual clinical care being offered to increase quality while containing costs within the healthcare delivery system. This necessitates providers to apply the most up-to-date information based on research, evidence-based medicine, and clinical experience while engaging patients more intimately in their care. It also demands a strategy for continually defining, monitoring, and optimizing the processes at the heart of care delivery. In addition, when our healthcare system commits to attaining clinical effectiveness on a large scale across all institutions, then we will be able to begin to balance the quality/cost equation (Basow, 2017).

Organizations can provide consistent, high-quality services, with staff reviewing the effectiveness of their practice against the most recent evidence and a reduction in ineffective treatments, increasing the population served's health gain within available resources (Williams & Ford, 2014).

In addition, the public's awareness of and demand for new high-tech and best practices is growing. Academics and clinicians are no longer the only ones defining, measuring, and improving clinical practice standards. Although current quality improvement perspectives favor focusing on systems and how they work rather than individuals and their competence, it is critical not to overlook staff selection and development, particularly health care providers, because technical competence is critical to adequate health care, and interpersonal skills can increase patient compliance and satisfaction. A communication breakdown is the most common source of serious complaints; competent employees are a valuable asset that rewards maintenance and development, and senior management is moral, if not legally, accountable for ensuring that employees are competent.

2.1.2 Efficiency

Efficiency refers to the most cost-effective use of healthcare resources, and it lies at the core of all healthcare systems. All publicly funded healthcare systems place high importance on efficiency. To ensure the most significant potential outcomes and waste minimization, limited resources must be managed sensibly and wisely.

Also, healthcare organizations will have the challenge of providing more patient care of higher quality with fewer financial and human resources in the following decades (Kerasidou, 2019).

From one perspective, efficiency may appear wasteful from another; the perspective from which efficiency is measured has significant implications for the measurement approach. In some cases, it is also critical to determine the outputs of interest and how they will be measured. A physician, for example, may perform CT scans efficiently in her office, but he may not appear efficient to a health plan if a less expensive diagnostic test could have been substituted. Health services (such as visits, medications, and admissions) and health outcomes are the two outputs (e.g., preventable deaths, functional status, and clinical outcomes such as blood pressure or blood sugar control)(Southern California Evidence-based Practice Center, 2008). Furthermore, we must understand that few systematic analyses of reliability and validity have been conducted on efficiency measures, and strategies for accounting for quality-of-care inefficiency measurement are not well developed. Without a good understanding of these challenges, these approaches are likely to induce resistance from providers and may result in unexpected consequences (Hussey et al., 2009)

2.1.3 Staff orientation

Providing more training, especially on the job, maintaining a safe and sociable work environment, keeping employees engaged, and boosting teamwork are all examples of being staff-oriented. Our people are our most valuable asset, and investing in them is the key to long-term success.

All employees should understand the fundamentals of their organization: what it is attempting to accomplish, why it is attempting to accomplish it, and how the individual employee contributes to these efforts. These messages are conveyed through orientation,

which provides a framework that shows the new employee where they fit into the organization and its goals (Wallace, 2009).

The degree to which hospital staff are appropriately qualified to deliver required patient care, have the opportunity for continued learning and training, work in positively enabling conditions, and are satisfied with their work is referred to as staff orientation (Veillard et al., 2005).

Low morale is visible to patients and is expressed in turnover and absence rates. In addition, sick staff can threaten patients and the organization, and high morale can compensate for low staffing levels.

In this dimension, the researcher will discuss staff training, the rate of absenteeism among the staff, and workload and excessive working hours.

2.1.4 Responsive governance

The need for good governance is increasingly recognized as a significant hurdle to achieving universal health coverage (WHO, 2018b).

Being responsive to the demands and requirements of the community and patients and meeting people's expectations is what responsive governance entails.

Hospitals are part of the healthcare system, and one of the main goals of any healthcare system is to promote and attain health, to be accountable for the needs and expectations of the population, and to do so in a way that is available, accessible, and achievable, as well as quality-oriented, which is consistent with our design.

2.1.5 Safety

Safety is an important aspect of hospital quality that affects patients, staff, and the environment. Patient safety indicators reflect the quality of care provided within the hospital, but they are focused on surgical complications and other iatrogenic events.

Furthermore, patient safety is a healthcare discipline that has evolved in response to the increasing complexity of healthcare systems and the resulting increase in patient harm in healthcare institutions. It aims to avoid and reduce risks, errors, and harm to patients during

the delivery of health care. Constant development based on learning from mistakes and negative experiences is a cornerstone of the discipline.

The safety of patients is an important part of delivering excellent basic health services. There is general agreement that excellent health care should be effective, safe, and concerned with the well-being of the patients. To get the benefits of excellent health care, health services must be timely, fair, integrated, and efficient. To ensure patient safety measures are successful, transparent policies, leadership ability, data-driven safety improvements, experienced health care personnel, and effective engagement of patients in their care are essential (WHO, 2017a).

Patient harm is one of the world's most significant health problems, and it's comparable in size to some of the most common diseases. The number of hospitalizations around the world annually is estimated at 421 million, and the number of adverse events that occur during these hospitalizations is estimated to be around 42.7 million. According to conservative estimates, patient injury is the 14th leading cause of morbidity and mortality worldwide (WHO, 2019a).

A study was conducted with the goal of comprehensively quantifying the occurrence, severity, and type of preventable patient harm in a variety of medical settings around the world. According to the findings, one out of every twenty people is exposed to avoidable harm in medical care. Despite the fact that the global patient safety policy agenda has supported a focus on preventable patient harm, there are few quality improvement techniques available, with the majority of them focusing on preventable patient harm rather than actual patient harm (preventable and non-preventable). Developing and implementing evidence-based mitigation techniques, particularly those aimed at preventing avoidable patient harm, could result in significant improvements in medical care quality while also being more cost-effective (Panagioti et al., 2019). To improve patient safety, system-wide action is required on a variety of fronts to identify and manage potential patient safety hazards and to implement long-term solutions. Healthcare providers must make continual improvements in their performance, environmental safety, and risk management practices in order to provide the safest possible care for their patients. These include infection control, medication safety, equipment safety, safe clinical practice, and a safe environment of care (Pittet & Donaldson, 2006).

A study was carried out in two tertiary hospitals in Oman to investigate patients' and healthcare professionals' perceptions of overall quality of care and patient safety standards. The study investigated the relationship between demographic characteristics and the quality of care and patient safety. When compared to magnet hospital standards, both patients and healthcare professionals rated the quality of treatment and patient safety as excellent, according to the study. Patients are thus satisfied with the level of the healthcare delivery system and value the healthcare services provided. This suggests that HCPs have broad core competencies and use appropriate quality assurance procedures and practices (F. Al-Jabri et al., 2021).

2.1.6 Patient centeredness

Patient-centered care is a care model that considers the patient's experience, values, needs, and preferences when planning, coordinating and delivering care. A therapeutic relationship between the patient and the team of healthcare professionals is a vital component of this model. Implementing a patient-centered care model has improved patient outcomes, made better use of resources, reduced costs, and increased patient satisfaction with care. Furthermore, it means providing individual patient preferences, needs, and values with respect and responsiveness, as well as ensuring that patient values guide all clinical decisions (Baker, 2001). In patient-centered care, an individual's health requirements and intended health outcomes are the driving force behind all health care choices and quality assessments. Patients are partners with their health care providers, and doctors serve patients from both a clinical perspective and an emotional, mental, spiritual, social, and economic one (Catalyst, 2017).

The patient is the center of health care quality; s/he should be treated with dignity, respect, and fulfillment of his/her expectations, keeping them satisfied with the provided services. Patient satisfaction assesses how well your medical practice treats patients. "How well" refers not only to the quality of care but also to a patient's satisfaction with the treatment he or she received. It is a measure of care quality that provides significant insight into many aspects of healthcare, including the effectiveness of their care and their level of comprehension (Practice Builders, 2019).

2.2 Literature review

2.2.1 Quality and quality indicators

In this section, the researcher highlights the indicators used for the quality assessment of health care services in this study.

"Quality of care is also a critical component of the right to health and the road to fairness and dignity for women and children," according to the World Health Organization definition of quality health services. To achieve universal health coverage, it is critical to provide health services that meet quality standards (WHO, 2017b).

Quality should be evaluated from the perspectives of key stakeholders (such as users, caregivers, taxpayers, politicians, and health managers) and against explicit criteria that reflect society's underlying values (Shaw, 2015). The top management of your organization must put the quality policy, quality targets, and customer-focused project-specific strategies into action (ISO 9001:2015 Guidance, 2015).

2.2.2 PATH TOOL

PATH TOOL: Performance Assessment Tool for Quality Improvement in Hospitals (PATH) (Groene, 2005). The instrument has been piloted to several hospitals in Europe with high responding rate.

Several studies attempted to assess the quality of health care services in our context in Palestine in Gaza hospitals by using the WHO PATH TOOL. A study conducted by (AbuSada, 2013a) about the quality of healthcare services at the EGH aimed to assess the quality of healthcare services at the EGH to improve the services provided to beneficiaries, thus contributing to improving their health status. The result showed that, regarding the availability of performance indicators at the EGH, with certainty to some extent, most of the performance indicators used at the EGH are available. Some require effort and searching between files and hospital records, while others need to be modified. Also, another study conducted by (Abu-Hassera, 2016) aimed to assess the institutional health quality of performance by identifying the extent of the application of the maternity hospital at Al Shifa medical complex regardless of the World Health Organization standards by using the PATH TOOL. The result showed that most of the World Health Organization standards in the

maternity hospital are not applied because of the severe shortage of material and human resources and the staff's lack of adequate knowledge of these criteria.

2.2.3 Indicators

The indicator refers to numerical data that quantifies input, output, process dimensions, and outcomes. A simple indicator or measure measures a single aspect of a process or a composite. A measurable element that provides information about a complex phenomenon (e.g., quality of care) that is difficult to capture is referred to as an indicator. An indicator provides data but not advice. It is not a direct measure (flag), but rather one that must be interpreted.

Furthermore, the term "indicator" is sometimes preferred when the measurement is related to performance but is not the sole measure of that performance (e.g., the number of complaints is an indicator of dissatisfaction but not an exclusive indicator). The metric is a predictor or "leading indicator" of higher-level performance (e.g., inpatient satisfaction might be a leading indicator of the sustainability of a health organization). A negative sentinel event is defined as "an unexpected occurrence involving death or serious physical or psychological injury." Indicators must be clear and concise in order for everyone to understand them. An indicator statement should include a description of the intended focus, the rationale for its use, supporting evidence, and the population expected to be affected. It is critical to ensure that everyone understands the terminology used in a discussion. This can be difficult if the terms are not defined clearly. Each indicator should be classified as either a process, an outcome, a rate-based event, or a sentinel event. Your research proposal should include data sources and collection methods. Healthcare performance measures can be process or outcome measures. Process measures provide an answer to the question, "Are we on the right track? Outcomes measures provide an answer to the question, "Are we doing things correctly?"

The use of clinical indicators is an important part of providing optimal patient care. To be successful on this route, studies must invest in further developing clinical indicators and using them as effectively as possible. It is important to link these indicators to an accreditation body and a reward system in order to improve the quality of practice (Wollersheim et al., 2007).

2.2.4 Facility infrastructure and work environment

Facility infrastructure includes facility density and distribution, facility design, facility amenities, and safety equipment and precautions, and it encompasses the physical availability and physical quality of facilities (PHCPI, 2019).

Many individuals worldwide do not have frequent and appropriate access to health supplies. Many medical devices are damaged, underutilized, or inappropriate for function in resource-constrained environments. Access is dependent on having adequate items accessible at reasonable pricing. The introduction of new drugs and other health goods and the increase in non-communicable illnesses are putting a growing strain on global health care systems and individuals who must pay out-of-pocket in the absence of government funding. Lack of access can harm patient outcomes if patients go undetected, untreated, or receive inadequate care, and it can contribute to the growth of antibiotic resistance (WHO, 2018b).

The health care infrastructure heavily influences the structural quality of a health system. Health service infrastructure shortcomings have been reported (Scholz et al., 2015).

Nurses' working conditions are recognized as a key factor in providing quality healthcare services (Moisoglou et al., 2020).

Hospitals have a significant impact on how the public perceives the performance of a country's healthcare system. It is a medical or surgical facility that provides medical or surgical care to the sick or disabled. They are complicated. Patients seek medical care in hospitals, and staff provides ongoing support by creating a healing environment that includes appropriate physical elements. Significant-quality efforts have provided new understanding and opportunities for hospital structural modifications. Rapid technological advancement has paved the way for intelligent infrastructure design, resulting in a more substantial infrastructure and more efficient use of resources, both of which contribute to high-quality healthcare services (FrontEnders, 2018). In addition, according to the WHO Building Blocks of a Health System, the facilities required for an effective health system include electricity, safe water, exam rooms with privacy from sight and sound, light sources, sanitation facilities (such as flush or pour toilets, piped sewer system, or septic tank, pit latrines, and composting toilets), communications equipment (such as cell phones, landline telephones, and shortwave radios), and emergency access (PHCPI, 2019). Because of the impact of the workplace

environment on job performance and organizational productivity, employees may be less productive (Makhbul & Muhamed, 2022). The organization shall determine, provide, and maintain the infrastructure necessary to operate its processes and achieve product and service conformity. Infrastructure is explained in the note as a) buildings and associated utilities; b) equipment, including hardware and software; c) transportation resources; and d) information and communication technology.

Infections connected to healthcare providers contribute to morbidity and mortality and a loss of healthcare and household resources worldwide. During their stay in the hospital, five to thirty percent of patients develop one or more illnesses, with a large percentage of these infections preventable. The number of infections increases during crises or precarious situations. People may opt not to seek medical help in some cases because nearby facilities are unavailable or treatment is uncertain owing to water, energy, or supply shortages (WHO, 2008).

A study conducted by (Van De Wetering et al., 2018) found that hospitals are increasingly using information technology (IT) infrastructures to improve their services. Although it is unclear how IT infrastructure affects clinical and operational excellence, there are some studies that suggest it may have some impact. The study found that having an adequate IT infrastructure capability and a strong digital capability are positively related, even though financial incentives can weaken this relationship. The study conducted by (Parashakti et al., 2020) found that the work environment and competence have a positive and significant effect on motivation and employee performance at Masmitra Hospital. Path analysis showed that the work environment and competence both directly and indirectly influence performance through motivation.

2.2.5 Return to ICU

An Intensive Care Unit (ICU) is a separate and self-contained hospital facility dedicated to handling patients with life-threatening illnesses, injuries, and complications and monitoring potentially life-threatening disorders. It provides specialist skills to support essential functions and employs the abilities of medical, nursing, and other workers with experience dealing with these difficulties (College of Intensive Care Medicine of Australia and New Zealand, 2011).

This indicator reflects the effectiveness and safety of work in medical and surgical wards; it is widely used and considered an important indicator in determining the technical performance and quality of work. Most readmitted patients require more extended hospitalization in ICU with a high burden of disease and cost-effectiveness of medical service.

Nurses face various problems while transferring patients from an intensive care unit (ICU) to a general ward. Such patients are at a greater risk of adverse outcomes, such as ICU readmission, increased nosocomial infections, and mortality, raising hospital expenses (Guest, 2017).

Several factors influence ICU discharge success, including facilitators and barriers at the patient and family, healthcare provider, and organizational levels. Effective provider-patient and provider-provider communication, as well as educating and engaging patients and families in the discharge process, are essential for a successful ICU discharge (Plotnikoff et al., 2020).

ICU readmissions are associated with worse patient outcomes, including hospital mortality and increased LOS (Mcneill & Khairat, 2020). Moreover, discharging patients from the intensive care unit (ICU) often necessitates balancing patient demands with available resources. Unplanned admission to the ICU ("bounce back") has been linked to higher resource consumption and poorer outcomes (Fakhry et al., 2013).

Intensive care readmission is linked to patient factors that reflect the severity and complexity of the illness, resulting in a higher risk of hospital death and a more extended stay. When making decisions about intensive care discharge, physicians should evaluate these risk factors to improve patient safety. Because readmission to an intensive care unit is associated with more complex and severe illnesses, readmission rates must be adjusted for case mix before being used as quality indicators (Kramer et al., 2012).

2.2.6 Prophylactic antibiotic availability and use

Antibiotics are often used to treat illnesses caused by bacteria. However, physicians may recommend taking antibiotics before treatment to reduce the risk of infection. Antibiotic prophylaxis is not suitable for everyone, and antibiotics, like any other treatment, should only be given when the potential benefits outweigh the dangers (Mark, 2016). Prophylactic

antibiotics can decrease the incidence of postoperative wound infections in indicated procedures. Clean-contaminated surgeries and prosthesis implantation have been the established grounds for prophylactic antibiotics, but additional indications are emerging that evaluate wound contamination, anesthesia risk, and the relative duration of the operation (Agarwal, 2013).

Antibiotic prophylaxis is used to reduce the risk of infection due to interventions. Antibiotic usage carries the possibility of side effects and the development of microbial resistance patterns. As a result, users should be carefully reviewed and based on solid evidence (Bootsma et al., 2008). The most commonly prescribed antibiotics before surgery are cephalosporin antibiotics such as cefazolin and cefuroxime. If you are allergic to cephalosporins, vancomycin may be prescribed. They can prescribe antibiotics if antibiotic resistance is a problem. Your doctor will most likely prescribe amoxicillin or ampicillin for dental procedures (Stubblefield & Slowiczek, 2016).

Preoperative antimicrobial prophylaxis is widely used by clinicians to prevent a wide range of infectious diseases, including rheumatic fever, recurrent cellulitis, meningococcal disease, recurrent uncomplicated urinary tract infections in women, cirrhotic patients, influenza, infective endocarditis, pertussis, and acute necrotizing pancreatitis, as well as surgical site infections. A variety of surgical procedures call for preoperative antimicrobial prophylaxis. The antimicrobials used for prophylaxis should be bactericidal, non-toxic, cheap, and active against the microorganisms that frequently cause surgical site infections after surgery. To maximize its effectiveness, intravenous prophylaxis should be administered 30 to 60 minutes before the surgical incision. Antimicrobial prophylaxis should be used only for a limited period (Enzler et al., 2011).

Improper surgical anti-microbial prophylaxis may be a predominant issue. And unseemly regimens begun with inappropriate timing and enduring longer than the specified term, are an issue that must be managed with instantly. In expansion, this issue must be causing not as it were a considerable increment in treatment costs but moreover an increment in antibacterial resistance (Palacios-Saucedo et al., 2017). According to the findings of a study conducted by (Karaali et al., 2020), inappropriate surgical prophylactic antibiotic (SP) administration is widespread, and the extension of SP to discharge prescriptions is a major source of noncompliance in our country. The presence of foreign bodies, physicians' concerns about infectious complications, high fever, and an increase in the number of white blood cells in the patients are all reasons for inappropriate SP.

2.2.7 Mortality rate

Mortality is one of the most widely used performance indicators for quality in health care. Moreover, a hospital quality indicator reflects the quality of care provided and identifies significant variations in the level of care provided. This indicator measures clinical effectiveness and safety. International interest in assessing outcomes for patients who have been hospitalized is growing. Such outcomes measurement varies, but they include system planning (policymakers, funding providers, and the community), promoting healthcare providers' transparency and accountability, providing surveillance systems to detect and correct underperforming organizations, and enhancing the overall performance of population health outcomes. The primary goal of such measurements at the level of the healthcare provider is to aid in the advancement of healthcare by informing quality improvement activities (Brand et al., 2013).

Hospital mortality rates may be valuable indicators of care quality, but careful statistical analysis is essential to prevent incorrectly attributing variation in death to differences in health care when it is actually due to case-mix differences (Goodacre et al., 2015).

Many research studies studied the state of mortality for patients with specific diseases like ischemic heart disease, strokes (cerebrovascular accidents), nosocomial infections, and hip fractures. Poor quality of healthcare is responsible for between 5.7 and 8.4 million deaths annually in low- and middle-income countries (LMICs), accounting for up to 15% of all deaths in these nations. Sixty percent of LMICs' deaths from conditions requiring medical attention are caused by poor healthcare, while the remaining deaths are brought on by underusing the health system (WHO, 2020).

However, due to the incomplete coding of the discharge summary by ICD10 codes, the researcher found it very difficult to get exact results about the mortality rate for a specific disease. Also the completeness of cause-of death globally is 49% (WHO, 2018c).

The researcher got the crude mortality rate in the Al shifa Medical Complex and compared it with previous years and with international standards. However, reviewing the literature about hospital mortality in general, it is found the crude death rates across UK hospitals in 2021 from 3.4% to 13.6% (average for UK is 8.5%) data obtained from UK statistics about hospitals.

2.2.8 Readmission Rate

Hospital readmission is defined by the Mayo Clinic as a patient's admittance to a hospital within 30 days of being discharged from a previous hospital stay. It is one form of data used to assess the quality of hospital care and the number of patients readmitted unexpectedly after a previous visit. An unexpected readmission occurs when a patient is readmitted to the hospital following a previous hospital stay for a surgical wound infection. Unplanned hospital readmissions might be connected or unrelated to the previous visit, and some readmissions are unavoidable. For a variety of reasons, unexpected hospital readmissions may be considered as wasteful spending by insurance companies and other payers (MayoClinic, 2020).

The 30-day readmission rate is utilized as a quality-of-care measure for providers, and it has grown increasingly crucial since any rise in unplanned readmissions might result in a reimbursement reduction (Alquthami, 2019). Also, a study aimed at identifying patients who are most likely to be readmitted and processes that need to be improved to develop tools to assist in minimizing early readmissions in this population. The study found that patients in poor health who use ten or more prescriptions daily and live in the community with home care are more likely to be readmitted to the hospital within 30 days following release. Readmissions after being discharged on a Friday or from a surgical unit are more common. Our findings point to patients who are most likely to be readmitted and discharge practices that need to be improved, providing the groundwork for future research and focused initiatives to minimize hospital readmissions in this population within 30 days (Glans et al., 2020).

In addition, readmission to the hospital is being used as a quality indicator, and payment incentives may be granted (Kaboli et al., 2012). Also, hospital readmission measures have been touted as a quality measure and as a means to bend the healthcare cost curve (McIlvennan et al., 2015). So, reducing re-hospitalization rates has attracted policymakers' interest as a strategy to enhance care quality and save costs. Re-hospitalizations are common and expensive among Medicare beneficiaries (Jencks et al., 2009). This is a study aimed to discover the factors that assisted in the elevation of readmission and range, rather than the exact result, which should be considered, indicating that there are factors such as demographics, procedure types, and individual institutional factors that are important and affect this outcome variable (Bernatz & Anderson, 2015).

2.2.9 Length of stay

The length of stay (LOS) is an important indicator of the effectiveness of hospital management. Reducing the number of days an individual spends in the hospital can help to prevent infection and medication side effects, improve treatment quality, and increase hospital profits. It is critical to strengthen hospital finances and implement institutional strategies to reduce patient medical costs. This can be accomplished by encouraging the efficient use of hospital resources and reducing hospital stays (Baek et al., 2018).

In the OECD, the average length of stay in hospitals (ALOS) is frequently used as a performance indicator. If all other factors remain constant, a shorter stay reduces the cost per discharge and shifts care from inpatient to less expensive post-acute care. The average number of days spent in the hospital with patients is referred to as ALOS (OECD, 2020).

There was a study conducted by (Nikuee et al., 2020), and this study aimed to investigate the relationship between LHS and the quality of nursing care in the neonatal intensive care unit (NICU),

The result of the study was that the length of stay and the quality of care had an inverse relationship. We can decrease the LHS by enhancing the quality of care.

In another study conducted by (Borghans et al., 2012), the purpose and setting were to present a bottom-up approach to developing interventions to shorten lengths of stay, and the result was that we would advise wards that have to reduce the length of stay to make the inventory themselves, using appropriate benchmark data and by using the matrix.

In addition, another study said that the length of stay (LOS) is a vital indicator of a hospital's performance. Reduced inpatient days mean a lower risk of infection and drug adverse effects, better treatment quality, and higher hospital profits, which lead to improved bed management.

There is a study aimed to determine which characteristics are linked to hospital stay length using electronic health data to manage hospital stays better, and the result was accurate knowledge of the elements that influence inpatient LOS, as well as gradual improvements in processing and monitoring, which may allow for more efficient inpatient LOS management (Baek et al., 2018).

2.2.10 Work-Related Injuries by Type

Occupational diseases are health conditions that can be caused by exposure to factors in the workplace or in the environment. Physical, chemical, biological, ergonomic, and psychosocial factors can all contribute to workplace injuries (WHO, 2001).

When an accident happens in the workplace, the first thing we notice is the direct cause. However, many elements influence the circumstances that may have influenced the eventual result. The initial shortcomings that led to the outcome might have been caused by indirect or underlying causes (OIT, 2011).

Many healthcare providers in low and middle-income areas are exposed to a wide range of hazards. These nations' safety measures and risk-reduction efforts are poor. Health care employees must be safeguarded from occupational risks since these hazards have the potential to cause illnesses and injuries and have a negative influence on health care worker retention and the quality of care provided (Rai et al., 2021). In a large workforce working in an environment where accidents and injuries can occur, accidents happen. According to the International Labor Organization, occupational accidents cause 2 million deaths each year. The Red Crescent was involved in a study conducted at the King Fahd Military Complex in Dhahran. The purpose of the study was to determine the nature, frequency, and causes of work-related injuries among paramedics. The findings revealed that paramedics and EMTs are particularly vulnerable to work-related injuries. The most common injuries were caused by verbal or physical abuse, needle stick injuries, and car accidents (Tarek M. Esmael et al., 2021).

Standard safety equipment and precautions include sterilization equipment, safe final disposal of sharps and medical waste, sharp boxes or containers in exam rooms, waste bins with lids and liners in exam rooms, surface or environmental disinfectants, single-use standard disposable or auto-disposable syringes, bar or liquid soap with running water or alcohol-based hand sanitizer, latex gloves, and guidelines for standard precautions (Primary health care performance initiative(PHCPI), 2019). Unsafe healthcare settings play a vital role in the development of several diseases. Legionellosis is a well-known risk connected with healthcare facilities, with an estimated ten percent of infections occurring in these settings. Sharps waste is highly contagious, even though it is produced in minor quantities. Because contaminated needles and syringes are frequently scavenged from waste areas and dump

sites and reused, they pose a risk. They can infect healthcare professionals, garbage handlers, and the general public if they are not adequately controlled (WHO, 2008).

The intention with dangerous medical equipment or patient secretions during a medical intervention causes accidental exposure to percutaneous needle sticks, sharp injuries (NSSI), and blood and other bodily fluids. A study compares the rates, distribution, and type of exposure to blood and bodily fluids and NSSIs of healthcare workers for the years 2019 (pre-pandemic period) and 2020 (pandemic era). The study also discovered that exposure to NSSIs was reduced throughout the pandemic era. However, there was no significant change between the pre-pandemic and pandemic periods regarding exposure to blood and bodily fluids. Training and awareness programs that are well-designed can successfully reduce exposure to NSSIs, blood and other bodily fluids, and respiratory acquired viruses (Diktas et al., 2021). A study was conducted with the goal of investigating the relationships between workplace violence, nurse outcomes, and patient safety. In addition, to investigate whether nurse burnout and job satisfaction play a role in the relationship between workplace violence and patient safety, the study discovered that workplace violence was associated with higher levels of burnout, lower job satisfaction, lower patient safety, and more incidents. Nurse burnout has been linked to lower patient safety and more adverse events. Improved patient safety is directly related to higher nurse job satisfaction. Nurses' burnout and job satisfaction acted as a buffer between workplace violence and patient safety (Liu et al., 2019).

A systematic review for workplace violence is described as an act of aggression in which employees are abused, intimidated, or attacked at work, including while traveling to and from work, posing an explicit or implicit threat to their safety, well-being, or health. This review aims to look at the effects that workplace violence can have on healthcare professionals, improve healthcare professionals' understanding of the consequences of workplace violence, and guide future research into identifying strategies that can effectively reduce workplace violence. The review found that workplace violence might lead to various negative impacts on health workers' psychological and physical health, such as increased stress and anxiety levels, feelings of anger, guilt, insecurity, and burnout (Liu et al., 2019).

A retrospective study conducted by (Liu et al., 2019b) was to explore patient injuries focusing on falls. Furthermore, on healthcare workers' incidents, injuries, and the situations they occurred. Injuries to patients and healthcare staff are still common in Swedish healthcare, and a significant portion of the accidents included a patient scenario.

2.2.11 Training

A planned and systematic effort to modify or develop knowledge, skills, or attitudes through a learning experience to achieve effective performance in an activity or range of activities is referred to as training. Its purpose in the workplace is to enable an individual to acquire the skills necessary to perform a given task or job adequately and to realize their full potential (Buckley & Caple, 2009).

The quality of employees and their development is a significant factor in determining long-term sustainability. Proper training for current employees helps them adjust to rapidly changing job requirements, and there are specific steps involved in identifying the training process in any health institution. First, the goals of the organization need to be determined. Then, a needs assessment must be conducted to determine which training needs are most important. After that, the objectives of the training program must be determined. Finally, the selection of trainee and modality of training must be done, and the training process applied. After training is completed, evaluation must be conducted to determine the effectiveness of the training.

The best way to learn a skill is to do it on the job. The employees are also able to use the job technique for a large group for its many benefits, such as lectures, specific study, films, television conferences or discussions, case studies, role-playing simulation, programmed instruction, and laboratory training and orientation. On-the-job training refers to activities conducted at a person's workplace in order to help them learn the job-related skills and knowledge they need in order to do their job. Employees learn in a setting where they must use the information and skills learned during on-the-job training. On-the-job training uses average or current workplace tools, machinery, documents, equipment, knowledge, and abilities to teach an employee how to efficiently execute his or her job. It occurs inside the typical working environment that a person encounters on the job. OJT is frequently used to teach fundamental workplace skills, but it also instills parts of workplace culture and performance expectations in new employees. OJT may also be a strategy corporations use to train new staff (Sree & Basariya, 2019). Sufficient size and skillsets in the health workforce are crucial to accomplishing any community health goal. However, countries at all levels of socioeconomic development face, to variable degrees, problems in education and training, deployment, retention, and recruitment of their health workforce's performance (WHO, 2016).

Health professionals must be trained to be more aware of their patients' requirements, including communication and information dissemination, and have in mind health literacy levels. A positive attitude toward patient involvement must also be fostered in professional training. These measures are an essential aspect of fostering a patient-centered culture committed to continual improvement (European Patients Forum, 2017).

An article investigates the effects of providing job training to temporary workers. According to the data, offering access to training considerably increases revenue, leading to better performance among higher-ability individuals ((Lyons, 2020). Another study, conducted by (Shen & Tang, 2018), sought to investigate the roles of training transfer and job satisfaction in the relationship between training and customer service quality. The findings show that training, both directly and indirectly, influences training transfer through the mediation of job satisfaction, which partially mediates the relationship between training transfer and customer service quality. Another study was conducted to determine the link between discipline, motivation, training, and health worker performance at the Abeli Community Health Center. The findings of this study revealed that health institutions increase health workers' knowledge by improving discipline, strong motivation, and training. Eventually, the quality of human resources and the functioning of healthcare organizations will improve (Akbar et al., 2020).

2.2.12 Workload and excessive working hours

Hospitalist physicians are under increasing pressure to maximize productivity, which may jeopardize care efficiency and quality. A study was carried out to assess the relationship between hospitalist workload and the efficiency and quality of inpatient care. According to the findings of this study, increasing hospitalist workload is associated with clinically significant increases in length of stay (LOS) and expense. According to the findings of the study, a hospitalist workload may have a negative impact on the efficiency and cost of care. To mitigate these potential issues, we must take steps to reduce the amount of work that hospitals assign to hospitalists (Elliott et al., 2014).

A study was conducted by (Kowalczyk et al., 2020). It was decided to look at the relationships between overworking and burnout, two common occurrences that damage employees' mental health, and their relationship with sick leave. Excessive workload increases burnout symptoms, encouraging nurses to take sick leave more frequently. While

hospital managers may view this as a positive phenomenon, it is clear from this study that this can only be done in the short term, and in the long term, it will be detrimental to hospital organization and care quality. Another study was conducted to explore the correlation between workload and occupational stress among nurses in the emergency department of Regional Public Hospital RSUD, and the finding was that workload contributes to occupational stress, meaning that the heavier the workload, the more severe the stress (Vanchapo et al., 2019). Another study has been conducted to understand the consequences of long working hours on workers' occupational health. The findings showed that people who worked long hours were more susceptible to various occupational health issues. Workers who worked long hours had a greater likelihood of developing occupational health issues, and among the health measures in the linked health condition, short sleep duration showed the highest relationship with working hours(Wong et al., 2019). Furthermore, a study aims to imply that working hours are related to burnout and that this relationship is mediated mainly by sleeping hours. The result was found to suggest that working hours are related to burnout and that this relationship is mediated mainly by sleeping hours (Lin et al., 2021).

2.2.13 Absenteeism of workers

Absenteeism is defined as failing to report for work when scheduled. It assesses staff orientation and safety.

Absenteeism reflects a person's motivation and job involvement. It has a significant impact on hospital operations because it is expensive to compensate for lost working hours, increased workload for remaining staff, lost productivity, and lower quality services if skilled personnel are not replaced. The psychological support program improved mental health and quality of life, as well as productivity in healthcare settings (Dalmasso et al., 2021).

Short-term absence is most disturbing because of its unpredictable nature, and it allows less time to modify the schedule, to take steps to replace absent workers; in this study, it will be calculated as a numerator as a total number of nursing staff calendar days realized as plan, denominator as a total number of nursing staff (nurses and nurse assistants) planned calendar days in one year.

Most countries have implemented a variety of strategies to reduce healthcare worker absenteeism. The context in which these interventions are implemented has a significant impact on their success (Kisakye et al., 2016).

In low-income countries, health worker absenteeism is likely to exacerbate human resources for health inadequacies and demand for quality and efficiency of health care delivery (Belita et al., 2013). Moreover, absenteeism among PHC providers can be addressed if efforts are made to remove legitimate gaps that lead health professionals to struggle informally. Such a lesson can help low- and middle-income countries improve their healthcare systems (Agwu et al., 2020).

In addition, a study conducted by (Oche et al., 2018) aimed to assess the pattern and reasons for work absenteeism among health care workers at the Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria. Their findings revealed that the most frequent reason for workers' absence was sickness or illness. Moreover, another study conducted by (Mbombi et al., 2018) investigated the effects of absenteeism on nurses who remained on duty at a tertiary hospital in Limpopo province. The study found that absenteeism had a negative impact on nurses' work productivity and morale. Another study quantifying the excess of sickness absenteeism among healthcare workers (HCWs) estimates the impact of a severe versus moderate influenza season and determines whether vaccination rates are associated with lower sickness absenteeism. The study's findings revealed that absenteeism among HCWs was higher during the severe season's epidemic period than during non-epidemic periods. A severe influenza epidemic has a more significant impact on HCW absenteeism than a moderate epidemic. Vaccination has a positive effect on absenteeism, although at a low rate. As a result, it may support healthcare facilities' recommendations for vaccinations for their employees (Gianino et al., 2021).

Furthermore, a study was conducted by (Mollazadeh et al., 2018) to determine the extent and causes of sickness absenteeism in a teaching hospital and whether there is a correlation between demographic and occupational factors. The finding was that the nursing group and sickness absence episodes were found to have a significant relationship. The flu, musculoskeletal disorders, and infectious diseases were the most common reasons for absence. Based on the findings, it is possible to conclude that factors such as the availability of flu vaccine and the provision of personal protection and infection control principles can reduce sickness absence due to infectious disease.

2.2.14 Management stands at the psychological, economic, and social conditions of the worker

Organizational leaders must understand their workforce's needs and determine whether any team members are more vulnerable to mental health difficulties than others, such as those with existing needs or current mental health difficulties, those with caring responsibilities in their personal lives, or those who have recently survived stress or trauma experience (Mohiyeddini et al., 2019). Also, excessive stress can have harmful consequences for the emotional and mental well-being of front-line workers. Stress can have harmful effects on your ability to provide quality care, increase your risk of developing depression and anxiety disorders, and lead to a higher risk of suicide (UNRWA, 2017b).

(Baljoon et al., 2018) conducted a review to investigate nurses' work motivation and the factors that influence it. Furthermore, the study discovered that several personal and organizational factors, which are critical in influencing nurses' work motivation, were frequently influencing nurses' work motivation. Employee motivation is influenced by a variety of factors, including the organization's efforts to improve worker competence, the availability of resources and processes, feedback or penalties associated with worker performance, and more indirect factors such as work culture. Motivation is described as an individual's willingness to work hard to achieve organizational goals in the workplace. Worker motivation is essential to the health sector's success since service quality, efficiency, and equality are all directly influenced by employees' desire to put in the effort. Although financial incentives are significant factors of employee motivation, they cannot and do not solve all issues with employee motivation. Worker motivation is a multidisciplinary process that straddles economics, psychology, organizational development, human resource management, and sociology (Franco et al., 2002).

A successful health workforce involves more than just having the correct personnel numbers. It is about acknowledging that health worker motivation, distribution, and retention are significant contributions to increased access and productivity and can only be achieved via responsive policy, Management, and governance. Improved data is also necessary to efficiently monitor and control health worker migratory movements—work of a high standard and workforce stability and responsiveness (Buchan et al., 2017).

2.2.15 Availability of medication and medical supplies

The World Health Organization (WHO) defines essential medications like those that address a population's top health priorities. They should be accessible in sufficient quantities, be inexpensive, and have proven efficacy, quality, and safety. When these conditions are met, essential drugs are one of the most cost-effective components of any healthcare system, with immediate and long-term health benefits. Medication and health technology are among six health system-building elements identified by the WHO. As a core component, medicines and health technologies do not exist in isolation from the other components of a health system. Essential medications are designed to be available in acceptable quantities, of assured quality, and in suitable dose forms within the context of functional health systems (Beigbeder, 2018). The core list includes a list of the most effective, safe, and cost-efficient medications for priority diseases and a list of the minimal drug required for a basic healthcare system. Priority conditions are chosen based on present and estimated future public health importance and the possibility for safe and cost-effective treatment (WHO, 2019a). Access to health products is a significant challenge in low- and middle-income countries because rising prices have also become a concern in wealthier countries. Access to health products is not only fundamental health and human right, but it is also a foundation of development; without preventative, diagnostic, and therapeutic tools, populations cannot prosper. As a result of these factors, the primary aim of establishing universal health coverage is contingent on universal access to vaccinations, medications, and other medical technology (WHO, 2019b).

In any context, access to medications is far more complicated than just a matter of intellectual property. The availability, affordability, and proper use of medications are all dependent on which drugs are chosen for inclusion on a national essential medicine list (Rutta, 2014).

A study was conducted to determine the impact of medication shortages on patient outcomes, clinical pharmacy operations, patient complaints, and institutional costs. The study's outcome was that medication mistakes and adverse events continue to be caused by medication shortages, resulting in inadequate patient care, excessive institutional expenses, and patient complaints. In addition, delayed care and canceled care have been reported due to shortages (McLaughlin et al., 2013).

2.2.16 Patient expectations

Based on the most recent patient survey, this indicator gauges how patients feel about their hospital stay as a whole. Patients are the ultimate judgment of patient-centeredness and their perceived impact on compliance (and ultimately outcomes), loyalty, and referrals to friends. Patients' assessments can be used to guide quality improvement efforts, measure the impact of quality improvement initiatives, and provide an accountability tool.

This indicator will illustrate sub-dimensions of patient-centeredness: Respect and privacy, meeting expectation, information and communication, the approach of care, hospital culture, and hotel services (physical comfort). The data will be obtained through a self-interviewed questionnaire.

When we have too many demands, it can cause a gap between meeting expectations and what is achievable. Unfortunately, as many of us have discovered the hard way, this can lead to patient resentment if and when expectations are not met. The gap can be bridged by focusing on the fundamentals of expectation management, a process that begins and ends with effective communication. Poor communication may be identified in 70% of clinical negligence claims, and global research suggests that clinicians can reduce their risk of litigation by improving their communication skills and managing patient expectations. A study by (Aghamolaei et al., 2014) measured the service quality gap in Hormozgan province's central hospital. According to the findings, this hospital could not satisfy its patients' expectations completely. As a result, efforts must be made to narrow the gap between patients' perceptions and expectations.

Also, patients and clinicians may have varied expectations regarding treatment results. This varies, but recognizing the differences in perspectives is vital. Complaints can arise from actual shortcomings in medical care and worries about other non-clinical issues or the patient's perception that something went wrong - when, in fact, from the clinician's viewpoint, the care was excellent (MDU, 2019). The expectation did not necessarily influence the outcome (Donnet et al., 2022). There was a study, and the purpose of this study was to measure the satisfaction level of the patients coming for health tourism following the received treatment services and the variables impacting their satisfaction. It has been concluded from this study that expanding the awareness of health tourism in a sustained way

is only achievable by assessing the expectations of the patients accurately and providing satisfaction via the fulfillment of these expectations (Of et al., 2017).

Although several studies in developed countries investigated the relationship between patient expectations and patient satisfaction, one study examined the relationship between patients' expectations and satisfaction in outpatient department consultations. There was a significant difference between pre-consultation and post-consultation expectations. Patient satisfaction was found to be improved by post-consultant anticipation of their perceived health state and perceived control over health. Furthermore, any disappointments or fears, prior health-care experience, and level of influence on the consultation all harmed satisfaction (Berhane & Enquselassie, 2016).

In addition, a study was conducted by (Pietrzykowski et al., 2022) to investigate if patient knowledge and expectations impact adherence to the treatment regimen in a 1-year follow-up. The study's first results revealed the presence of a relationship between patient expectations and long-term adherence to therapy.

Chapter Three

Methodology

The adopted methodology to accomplish this chapter will include the following issues: study design, type of study sample, study population, and ethical consideration. Also, it presents the instruments which were used in this study, piloting, data collection process, data prescribing, and data analysis. Finally, it presents the selection criteria and limitations of the study.

3.1 Study design

The researcher used a triangulated design: a descriptive, analytical, and cross-sectional one to assess the quality of healthcare services at Al-Shifa Medical Complex in the Gaza Strip in medical and surgical departments compared to modified WHO PATH indicators. Triangulation provided a combination of a quantitative questionnaire for inpatients and healthcare providers and a qualitative design through in-depth interviews with the key stakeholders of the complex. The quantitative analysis was included. Inpatients at different wards (medical and surgical) with different diseases and illnesses who have been discharged during the study and all healthcare providers (physicians and nurses) employed in medical and surgical wards. They interviewed and filled out the questionnaire. This design was chosen because it best describes the current performance situation at hospitals. It is less expensive and enables the researcher to meet the study objectives quickly.

3.2 Study population

1. Inpatients at different wards (medical, surgical) with different diseases and illnesses who had been discharged during the study period.
2. Healthcare providers (physicians and nurses) employed in different wards (medical, surgical). The total number of healthcare providers is 485 (285 physicians and 200 nurses).
3. The complex database and statistics in 2020 and 2021 to extract administrative, technical, and indicators-related data for various indicators for different periods.
4. The key managers at the SHMC (4 key managers) (The key managers included the general director, medical director, head of nursing, and training and development director).

3.3 Samples and sampling

Table (3.1): Samples and sampling of patients in departments

Category	Patient	Patient
	N (%)	n (%)
Medical dept. (5 dpt.)	104 (32.8%)	58 (32.8%)
Surgical dept. (12dept.)	213 (67.2%)	117 (67.2%)
Total (%)	317 (100%)	175 (100%)

- The first sample of the study included patients who were discharged during the data collection period. The researcher selected 175 participants using a probability stratified random sample from 17 wards (12 surgical wards and five medical wards). Patient samples were distributed as a percentage of the total number of samples and distributed over the total number of wards, where samples were taken from the medical wards by 32.8%, which constitutes the number of 58 samples distributed evenly over 5 medical wards. Samples were taken from the surgical wards with a percentage of 67.2%, which constitutes a total of 117 samples distributed evenly over 12 surgical wards.

- The second sample included healthcare providers using a probability-stratified random sample.

Table (3.2): Samples and sampling of healthcare providers in departments

Category	Physician	Nurse	Total	Physician	Nurse	Total
	N (%)	N (%)	N (%)	n (%)	n (%)	n (%)
Medical dept.	62 (12.7)	51 (10.5)	113 (23.2)	28 (21.7)	23 (25.3)	51 (23.2)
Surgical dept.	223 (45.9)	149 (30.9)	372 (76.8)	101 (78.3)	68 (74.7)	169 (76.8)
Total	285 (58.6)	200 (41.4)	485 (100)	129 (100.0)	91 (100.0)	220 (100.0)

The researcher was asked to select how much each stratum (physicians and nurses) represented the population.

The researcher selected 220 participants from the total population (285 physicians and 200 nurses) and found that it represented (129 physicians) 58.6% and (82 nurses) 41.4% of the total population to represent the population from 17 wards for nurses (12 surgical wards and five medical wards) and 25 wards for physicians (15 surgical wards and 10 medical wards). Samples were distributed from physicians and nurses as a percentage of the total number of samples and distributed over the total number of wards, where samples were taken from physicians who made up 58.6% of the total number of samples: (12.7% for physicians in medical wards and 45.9% for physicians in surgical wards), i.e., 129, which represents the number of 28 samples for physicians in medical wards, and these samples were distributed to 10 medical wards for physicians, as well as 101 samples to physicians in surgical wards, which were distributed to 15 surgical wards for physicians. As for nursing, samples were taken from the nurses, who constituted 41.4% of the total sample number (10.5% nursing in the medical wards and 30.9% in the surgical wards), i.e., 91 samples, representing the number of 23 nursing samples distributed equally among five nursing wards in the medical nursing wards. Also, 68 nursing samples were distributed equally to 12 surgical nursing wards.

-The third sample of the study included medical reports, databases, and hospital statistics were reviewed for clients and required data for employees from the database about important variables that needed to be documented to extract the indicators of interest.

- The fourth sample of the study included a non-probability purposive sample of 4 key managers was interviewed. The key managers sample included (the general director, medical director, director of nursing, and the training and development manager). The idea of including this sample is to dig deep and understand in-depth the perspectives about the quality of hospital care. The qualitative component was conducted after the quantitative one to explore issues that emerged from the quantitative study.

3.4 Study setting

The study was conducted at Al Shifa Medical Complex, where the healthcare providers and clients were recruited to participate.

3.5 Data collection and study instrument

This study included four instruments;

1. The first one was a structured interview questionnaire for patients who had been discharged during the study period and consisted of three main domains: the first domain is general information about the demographic characteristics of respondents and information about residency in the hospital. The second domain is patient perception, divided into six sub-domains distributed over 35 paragraphs related to the WHO quality indicators of health care.
2. The second instrument was a self-administered structure questionnaire for health care providers and consisted of three main domains: the first domain is general information about the demographic characteristics of the respondents. The second domain, health provider perception, is divided into five sub-domains related to the WHO indicators of quality of health care.

The questionnaires were written in Arabic to assist with understanding the population sample's content. Unnecessary personal data and complex and duplicated questions were avoided. The questionnaires were provided with a cover letter to explain the purpose of the research and the way of responding, and the information was secured to encourage a high response from participants. Following ethical and administrative approval from all relevant parties was obtained, the researcher collected the data by himself.

3. The third instrument, a face-to-face interview with semi-structured questions with the key managers at the Al Shifa Medical complex (4 managers), was conducted in the Arabic language and in private locations convenient to the interviewees. Questions focused on the perception of the quality of complex health care services and the results of quality indicators that have been used in the research study.

4. The fourth instrument was a secondary review of the complex health information system and database for the patients. Healthcare provider information and various details were reviewed about essential variables.

In this instrument, the researcher collected data about three subdomains: mortality rates, readmission rates, length of stay in medical and surgical wards, and absenteeism of healthcare providers.

3.6 Study period

The study proposal was approved in January 2020. Data collection took place in October 2021 and continued through June 2022. Data analysis and reporting were completed in September 2022.

3.7 Scientific rigor

Quantitative part

3.7.1 Validity

1. The interviewed clients' questionnaire was adopted from a previous study performed at EGH (AbuSada, 2013b) about assessing the quality of healthcare services at the European Gaza Hospital. The questionnaire was sent to 12 experts to validate the questions and their relation to the study's domains. Comments from the experts were considered, and modification was performed accordingly.

2. A self-administered questionnaire constructed by the researcher (self-report structure questionnaire for health care providers) based on the literature review and past experiences to assess the quality of health care services at Al Shifa Medical Complex in the Gaza Strip. The questionnaire was sent to 12 experts to validate the questions and their relation to the study's domains. Comments from the experts were considered, and modification was performed accordingly.

3.7.2 Reliability

The researcher used internal consistency (Annex10) to measure each item related to the domains of the study. Also, the researcher used the Cronbach alpha coefficient (Annex10)

to measure how items are closely related as a group. The Cronbach alpha coefficient was more significant than 0.7, and the instrument was satisfactory.

Additionally, the researcher used the split-half method, which depends on finding the Pearson correlation coefficient between the mean of arranging odd and even questions in each questionnaire field. Then, correcting the Pearson correlation coefficients will be done using the Spearman-Brown correlation coefficient correction. According to the Split-half method, the items in the reliability group are between 0.0 and + 1.0, with a p-value less than 0.05, so all the correlation coefficients are significant and, according to the Split-half method, the items in the reliability group are reliable.

Table (3.3) Reliability Statistics

Questionnaire Type	Cronbach's Alpha	No of Items
Patients' questionnaire	0.926	35
Healthcare providers questionnaire	0.940	63

3.8 Pilot Study

The researcher carried out a pilot study on 20 patients and 33 healthcare providers to test the questionnaires' reliability. And it's included in the study samples.

3.9 Data collection

The researcher distributed the questionnaires to the participants during their working hours in the day and evening work shifts and then received them after completing the questionnaires. Moreover, patient questionnaires are filled in during the patient discharge process in the targeted wards. The average time for filling out the questionnaire was 20 minutes. The covering letter of the questionnaire outlined the title, the purpose of the study, and the researcher's identity.

3.10 Response Rate

The total target population was 220 participants for the healthcare provider questionnaire. Two hundred twenty of them positively responded, with a response rate was 100%.

Moreover, the total target population was 175 participants for the patient questionnaire. One hundred seventy-five of them positively responded, with a response rate was 100%.

3.11 Data management and statistical analysis

Quantitative part

The researcher used the SPSS program, version 25. for data entry and analysis. The collected data were analyzed by using the SPSS software program. After data entry and data cleaning, the researcher performed frequency distribution for all variables of the questionnaires. After that, the researcher performed recoding for continuous variables. The researcher used simple statistics including frequencies, means and percentages. Also, independent sample t test, One-way ANOVA and Pearson correlation were used.

Qualitative part

The open coding thematic analysis method (Annex11) was used to analyze the transcripts of the in-depth interviews. The researcher obtained the main findings from the transcripts of the interviews. Then, categorization of the related ideas and comparison and integration between the quantitative and the qualitative findings were done to enrich the data collection.

3.12 Ethical Matters and Procedures

An official letter of approval to conduct the study was obtained from the Helsinki Committee in the Gaza Strip (Annex 2). Also, an official administrative letter was obtained from MOH to conduct the study at the Al Shifa Medical Complex (Annex 3). Every participant's patient or HCP were provided with a complete explanation form attached to the questionnaires, both verbally and in writing (Annex4) and (Annex5). This form included the purpose of the study, assurance about the confidentiality of the information, and instructions on how to respond to the questionnaire. Also, it included a statement indicating that the participant has the right to refuse or participate in this study. Participation was optional; anonymity and confidentiality were given and maintained. Also, all data were taken from the system's database for patients and employees and were treated with high care and confidentiality.

3.13 Limitations of the Study

1. The presence of the COVID-19 epidemic and the procedures followed that impede work in the study.
2. The large size of the study place and its components reflect the difficulty of accessing places, providers, and patients.
3. Long study period; the study consumed more time than initially anticipated.
4. The incompleteness of data from databases in the complex led to resorting to more complicated methods to obtain information, such as resorting to the Information Systems Unit at the Ministry of Health.
5. The lack of a comprehensive electronic system inside the complex that includes all the information that was accessed with difficulty.
6. The inability to arrange and hold meetings in an easy way with the directors of the complex and meet them after great difficulty.
7. Obtaining patients intended to be discharged from hospital departments was not easy, reaching them and obtaining the required number.

Chapter Four

Results and Discussions

4.1 Health care providers' part

4.1.1 Sociodemographic characteristics of health care providers

The study sample consisted of 220 health care providers, (129 physicians and 91 nurses) from medical and surgical departments at Al Shifa hospital. Their characteristics are illustrated below.

Table (4.1): Distribution of study participant by sociodemographic characteristics

Variable	Category	Physician n (%)	Nurse n (%)	Total n (%)
Department	Medical	28 (21.7)	23 (25.3)	51 (23.2)
	Surgical	101 (78.3)	68 (74.7)	169 (76.8)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
Gender	Male	93 (72.1)	54 (59.3)	147 (66.8)
	Female	36 (27.9)	37 (40.7)	73 (33.2)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
Age	≤ 30 years	16 (12.4)	23 (25.3)	39 (17.7)
	31 – 40 years	81 (62.8)	64 (70.3)	145 (65.9)
	≥ 41 years	32 (24.8)	4 (4.4)	36 (16.4)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
	Mean= 36.55, SD= 6.365 years			
Marital status	Married	110 (85.3)	81 (89.0)	191 (86.8)
	Unmarried	19 (14.7)	10 (11.0)	29 (13.2)
	Total	129 (100.0)	91 (100.0)	220 (100.0)

Table (4.1) showed that 28 (21.7%) of physicians were from the medical departments and 101 (78.3%) were from the surgical departments, while 23 (25.3%) of nurses were from the medical departments and 68 (74.7%) were from the surgical departments. In addition, 93 (72.1%) of physicians were males and 36 (27.9%) were females, while 54 (59.3%) of nurses were males and 37 (40.7%) were females. The results also showed that 81 (62.8%) of physicians and 64 (70.3%) of nurses were from the age group 31 – 40 years old. Most of

study participants were married 110 (85.3%) of physicians and 81 (89%) of nurses were married.

Table (4.2): Distribution of study participant by work-related characteristics

Variable	Category	Physician n (%)	Nurse n (%)	Total n (%)
Qualification	Intermediate diploma	0 (0)	19 (20.9)	19 (8.6)
	High diploma	4 (3.1)	23 (25.3)	27 (12.3)
	Bachelor	81 (62.8)	44 (48.4)	125 (56.8)
	MSc / PhD	44 (34.1)	5 (5.5)	49 (22.3)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
Job title	Subordinate	94 (72.9)	76 (83.5)	170 (77.3)
	Head of division	20 (15.5)	5 (5.5)	25 (11.4)
	Head of department	15 (11.6)	10 (11.0)	25 (11.4)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
Experience in the hospital	≤ 5 years	29 (22.5)	12 (13.2)	41 (18.6)
	6 – 10 years	39 (30.2)	33 (36.3)	72 (32.7)
	11 – 15 years	38 (29.5)	36 (39.6)	74 (33.6)
	≥ 16 years	23 (17.8)	10 (11.0)	33 (15.0)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
	Mean= 10.96, SD= 6.037 years			
Experience in the department	≤ 5 years	48 (37.2)	19 (20.9)	67 (30.5)
	6 – 10 years	34 (26.4)	39 (42.9)	73 (33.2)
	11 – 15 years	30 (23.3)	28 (30.8)	58 (26.4)
	≥ 16 years	17 (13.2)	5 (5.5)	22 (10.0)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
	Mean= 9.20, SD= 5.800 years			
Income	≤ 1800 NIS	41 (31.8)	76 (83.5)	117 (53.2)
	1801 – 2400 NIS*	24 (18.6)	5 (5.5)	29 (13.2)
	2500 – 3000 NIS	43 (33.3)	5 (5.5)	48 (21.8)
	> 3000 NIS	21 (16.3)	5 (5.5)	26 (11.8)
	Total	129 (100.0)	91 (100.0)	220 (100.0)
	Mean= 2078.74, SD= 1038.478 NIS			

*NIS= New Israeli Shekel

Table (4.2) showed that 81 (62.8%) of physicians and 44 (48.4%) of nurses have bachelor degree, 94 (72.9%) of physicians and 76 (83.5%) of nurses were subordinates, 38 (29.5%) of physicians and 36 (39.6%) of nurses have between 11 – 15 years of experience in the hospital ($m = 10.96$, $SD = 6.037$ years), 34 (26.4%) of physicians and 39 (42.9%) of nurses have 6 – 10 years of experience in their department ($m = 9.20$, $SD = 5.800$ years), 41 (31.8%) of physicians and 76 (83.5%) of nurses have a monthly income of 1800 NIS and less ($m = 2078.74$, $SD = 1038.478$ NIS). This result is consistent with a study conducted by (Abu harbeed, 2021) that found 84.9 % of HCP have a bachelor's degree or more and a monthly income of 1800 NIS or less is 44.6%, and the result is inconsistent with a study conducted by (Abu Hasera, 2016) that found 70% of HCP have a bachelor's degree or more, 93.1% of HCP are subordinate, and 75.5% have less than 10 years of experience. Moreover, these results are consistent with reports and statistics issued by the Palestinian Ministry of Health in the Gaza Strip (MOH, 2021). According to these findings, which were presented to the researcher, 54% of the nursing staff within the departments held a bachelor's degree or higher, with the remaining personnel holding a diploma. Although the data indicate that there are not many nurses with bachelor's degrees, I think those with diplomas have a wealth of expertise that enables them to work in various parts of the complex and manage a variety of disease cases. Also, in the physician category, it is clear that 62% of them hold a bachelor's degree and 34% hold a master's degree or more. Based on these results, I believe that physicians who have a bachelor's degree deal with all types of patients and have experience criteria that also come into play here. Moreover, 34 (26.4%) of physicians and 39 (42.9%) of nurses have 6–10 years of experience in their department; these results reflect the ability to deal with all patients in all departments. In addition, 41 (31.8%) physicians and 76 (83.5%) nurses have a monthly income of 1800 NIS or less. This reflects the financial crisis that all classes of Ministry of Health employees, including physicians and nurses, are experiencing, as well as the fact that salaries are not paid in full in the Gaza Strip and the financial crisis that the Ministry of Finance is going through.

4.1.2 Quality of health services as perceived by health care providers

4.1.2.1 Clinical effectiveness of health services

Table (4.3): Infrastructure and work environment (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	Equipment and basic supplies needed to provide the services are available constantly	2.7	23.2	59.1	11.4	2.3	2.89	0.741	57.8	5
2	The equipment and supplies needed to provide the services are modern	4.1	27.7	54.5	11.4	2.3	2.80	0.780	56.0	6
3	Medical devices are monitored and maintained by maintenance staff regularly	2.7	25.9	51.8	17.3	2.3	2.90	0.791	58.0	4
4	The needed diagnostic analysis and examinations are available	3.2	23.6	54.5	15.0	3.6	2.92	0.810	58.4	3
5	There is adequate computers that assist in providing health services	5.9	28.6	53.2	10.9	1.4	2.73	0.786	54.6	7
6	There are places equipped to provide health service in a good manner and without any disturbance	6.4	36.8	45.9	9.5	1.4	2.63	0.798	52.6	11
7	There are designated and equipped places for the staff's rest period	20.0	32.3	41.4	5.5	0.9	2.35	0.891	47.0	19
8	The illumination inside the departments is appropriate to provide health services	10.5	32.7	45.0	9.5	2.3	2.60	0.883	52.0	13
9	Appropriate ventilation systems are available to provide the required health service	12.3	35.5	42.3	8.6	1.4	2.51	0.868	50.2	14

Table (4.3): Continued

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
10	Suitable central heating systems are available to provide the required health service	18.2	33.6	40.5	7.3	0.5	2.38	0.881	47.6	18
11	Toilets are suitable for the use of hospital staff are available	18.6	34.1	35.5	11.4	0.5	2.41	0.934	48.2	17
12	Drinking water and adequate hotel services are available for the hospital staff	27.3	32.7	30.9	7.7	1.4	2.23	0.982	44.6	20
13	Medical waste is properly sorted in the department	3.2	26.8	44.5	20.9	4.5	2.97	0.888	59.4	2
14	Infection control services are available within the complex	4.1	24.1	45.5	21.4	5.0	2.99	0.907	59.8	1
15	Fire alarms are available in the corridors of the complex	5.9	37.3	42.3	12.3	2.3	2.68	0.850	53.6	10
16	Equipment and tools are available to deal with fires within the corridors of the complex	8.6	32.3	43.2	12.7	3.2	2.70	0.913	54.0	8
17	There are emergency exits inside the complex	9.1	37.7	37.7	11.8	3.6	2.63	0.934	52.6	12
18	Efficient electric elevators are available within the complex	13.6	38.6	39.1	7.3	1.4	2.44	0.866	48.8	16
19	Effective communication systems are available within departments	7.3	33.6	44.1	13.2	1.8	2.69	0.858	53.8	9
20	The number of beds in each room is proportional to the size of the rooms	16.4	35.0	37.3	9.5	1.8	2.45	0.938	49.0	15
Overall average							2.64	0.592	52.8	

As presented in table (4.3), the highest score was in item “infection control services are available within the complex” with mean score 2.99 and mean percent 59.8%, followed by “medical waste is properly sorted in the department” with mean score 2.97 and mean percent 59.4%, and “the needed diagnostic analysis and examinations are available” with mean score 2.92 and mean percent 58.4%, while the lowest score was in “drinking water and adequate hotel services are available for the hospital staff” with mean score 2.23 and mean percent 44.6%, followed by “there are designated and equipped places for the staff’s rest period” with mean score 2.35 and mean percent 47%. The overall mean score was 2.64 and the mean percent was 52.8%. As reported by the director of nursing, "there is adequate clean linen for beds, toilets are cleaned frequently, but some patients and escorts do not maintain the cleanliness of the toilets." Also, this result is congruent with the study conducted by (Abu Hasera, 2016) who found there was a perception among the sample members of the parameters of this field with a mean percent of 51.3%. In addition, the result was congruent with the study conducted by (Scholz et al., 2015) that showed after a full assessment of the facility's infrastructure was undertaken by healthcare professionals, a serious infrastructural deficiency was revealed. The researcher attributes the fact that the infrastructure field obtained approval to a small degree to the presence of a building from the hospital buildings that were removed because they were very old, like the internal medicine building, in addition to the fact that the rest of the hospital facilities needed restoration and maintenance. However, hospital property is not periodically maintained to prolong the useful life of such property, whether equipment, buildings, or any other hospital asset, and the economic and political situation of the Palestinian government, and the existence of a division between the two parts of the country led to the deprivation of Gaza Strip from having approved budgets funded by donors. As well as the feet of the buildings, many facilities are presented. The hospital was damaged and destroyed in the absence of the periodic maintenance that must be done on the buildings. With regard to devices and equipment, when a device maintenance request is requested, the Engineering and Maintenance Department is delayed in responding to the request and attending to the device, and in most cases, the devices need spare parts that are not available inside the Gaza Strip. Because of the siege and division that our beloved sector suffers from, or the lack of budgets for improvement and infrastructure development, this was confirmed by the key manager when they were interviewed. In this regard, *the medical director said "that instability of the electricity supply caused damage to the medical equipment, and deficiency of spare parts made the maintenance of damaged equipment very difficult."*

Table (4.4): Return to ICU (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	Complications occur for some cases after they are discharged from the ICU to the general departments and are re-entered for ICU again during the first week of the date of discharge	5.9	24.1	48.6	18.6	2.7	2.88	0.873	57.6	4
2	There is vigorous follow-up and close treatment of cases that are out of ICU by the health staff	4.1	20.0	41.4	25.9	8.6	3.15	0.975	63.0	3
3	The health staff has sufficient experience to deal with cases coming from ICU	1.4	10.9	48.2	30.9	8.6	3.35	0.838	67.0	1
4	There is a reason to re-enter the ICU again	2.3	13.6	49.5	24.5	10.0	3.26	0.898	65.2	2
5	An ICU bed can be easily found for re-entry cases	9.1	20.9	53.2	14.5	2.3	2.80	0.879	56.0	5
Overall average							3.08	0.536	61.6	

Table (4.4) showed that the highest score was in item “the health staff has sufficient experience to deal with cases coming from ICU” with mean score 3.35 and mean percent 67%, followed by “there is a reason to re-enter the ICU again” with mean score 3.26 and mean percent 65.2%, while the lowest score was in “an ICU bed can be easily found for re-entry cases” with mean score 2.80 and mean percent 56%. The overall mean score was 3.08 and the mean percent was 61.6%. This result is consistent with the study conducted by (Abu Hasera, 2016) that showed there is a low perception about return to ICU domain with a mean percent of 56.06%. In addition, these results are congruent with the study conducted by (Abu Sada, 2013) that found the readmission to ICU at EGH is about 1%, which is regarded as very low and reflects very good work quality. *By interview with the medical director, he said "that very few patients who are discharged from ICU to the medical department are re-admitted to ICU. The doctors and the nurses are well-trained and they are competent to manage post-ICU patients."* The researcher attributed the presence of experienced workers and trainers to dealing with cases that come out of intensive care due to continuous training within the complex and giving nursing repeated courses such as BLS courses, as well as doctors, most

of whom are enrolled in the Palestinian board programs in the specialties of surgery and internal medicine, and this was confirmed by the key manager when they interviewed.

Table (4.5): Prophylactic antibiotic availability and use (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	Prophylactic antibiotics are available in the reception and emergency departments.	7.3	26.4	51.8	12.7	1.8	2.75	0.835	55.0	5
2	Prophylactic antibiotics are available as needed within the general departments.	1.4	25.0	55.0	16.8	1.8	2.93	0.737	58.6	3
3	Prophylactic antibiotics are always provided from the pharmacy without hindrances.	3.6	24.1	54.1	15.9	2.3	2.89	0.792	57.8	4
4	The use of preventive antibiotics is rationalized in a manner that does not conflict with the interest of the recipients of the service.	2.7	21.4	54.5	17.3	4.1	2.99	0.814	59.8	2
5	All patients receive prophylactic antibiotics according to an existing protocol inside the complex	1.8	21.8	53.6	17.7	5.0	3.02	0.819	60.4	1
Overall average							2.91	0.654	58.2	

Table (4.5) showed that the highest score was in item “all patients receive prophylactic antibiotics according to an existing protocol inside the complex” with mean score 3.02 and mean percent 60.4%, followed by “the use of preventive antibiotics is rationalized in a manner that does not conflict with the interest of the recipients of the service” with mean score 2.99 and mean percent 59.8%, while the lowest score was in “prophylactic antibiotics are available in the reception and emergency departments” with mean score 2.75 and mean percent 55%. The overall mean score was 2.91 and the mean percent was 58.2%. This result is consistent with the study conducted by (Karaali et al., 2020) that found there is an inappropriate use of prophylactic antibiotics in surgery. In addition, another study conducted by (Palacios-Saucedo et al., 2017) found the same result. After discussing the results with

key managers about this issue, they agreed that there was an inappropriate use of prophylactic antibiotics in departments and, consequently, the cause of underuse is the unavailability of these drugs like cefazolin very often in the hospital and another reason is doctors are not sufficiently committed, and this issue needs quality improvement. *By interview with the training and development manager he said, "there is a shortage in the new generations of antibiotics, and sometimes we have to use alternative drugs which is less effective. In addition, there is critical shortage of medication from the essential drug list due to the siege and inadequate supply from the MoH in Ramallah."*

4.1.2.2 Staff orientation and safety

Table (4.6): Work-related injuries (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	I was informed of the expected occupational diseases while on the job.	6.4	8.2	35.0	43.2	7.3	3.37	0.963	67.4	2
2	I was trained to avoid injuries resulting from my work performance.	6.8	10.5	32.7	42.3	7.7	3.34	1.000	66.8	3
3	I received the necessary vaccination to prevent possible diseases	4.5	8.2	31.8	47.3	8.2	3.46	0.923	69.2	1
4	Work injuries are documented by the safety supervisor at the complex	5.5	11.8	32.3	44.5	5.9	3.34	0.954	66.8	4
5	I had previous injuries during my work	14.5	6.8	32.7	40.9	5.0	3.15	1.115	63.0	7
6	The injured employee is transferred to conduct the necessary examinations after the injury	6.4	9.1	34.1	45.9	4.5	3.33	0.938	66.6	5
7	The condition of the injured employee is followed up clinically and the necessary remedial measures are taken	6.8	8.6	36.8	42.7	5.0	3.30	0.947	66.0	6
Overall average							3.32	0.810	66.4	

Table (4.6) showed that the highest score was in item “I received the necessary vaccination to prevent possible diseases” with mean score 3.46 and mean percent 69.2%, followed by “I was informed of the expected occupational diseases while on the job” with mean score 3.37 and mean percent 67.4%, while the lowest score was in “I had previous injuries during my work” with mean score 3.15 and mean percent 63%, followed by “the condition of the injured employee is followed up clinically and the necessary remedial measures are taken” with mean score 3.30 and mean percent 66%. The overall mean score was 3.32 and the mean percent was 66.4%. This result is consistent with the study conducted by (Tarek M. Esmael et al., 2021) that found the most common injuries were needle stick injuries, and this result was confirmed by the key manager when they were interviewed, and this result is inconsistent with the study conducted by (Abu Hasera, 2016) that found most of the hospital staff did not receive the necessary vaccinations to prevent the diseases that may be infected during the provision of the service in the hospital. *As mentioned by the medical director, "work-related injuries are very rare, and most of the injuries are caused by needle stick during the process of medication preparation and administration."*

The researcher attributed the fact that the employees took the necessary vaccinations at the Al Shifa medical complex because the preventive medicine within the Ministry of Health follows up well on the issue of vaccinations for students of health professions in universities before employment, as well as workers inside health facilities after employment, and the lack of follow-up of cases that become infected as a result of the employees' lack of awareness of the seriousness of work injuries and the lack of training to avoid them.

Table (4.7): Training (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	I receive training according to my needs periodically within the complex.	8.2	24.5	45.0	16.8	5.5	2.87	0.973	57.4	3
2	I receive training on my training needs periodically within the complex.	10.0	26.4	43.2	15.0	5.5	2.80	0.997	56.0	6
3	The necessary training of the employees is done according to the needs of the employees.	8.2	25.9	45.5	15.9	4.5	2.83	0.949	56.6	5
4	I participate in determining the department's training needs.	8.2	24.5	44.5	17.3	5.5	2.87	0.976	57.4	4
5	Training contributes to the development of my professional performance.	3.2	21.8	46.4	18.2	10.5	3.11	0.968	62.2	1
6	The administration follows up on the implementation of what has been achieved in the training process.	6.8	20.9	46.4	20.5	5.5	2.97	0.953	59.4	2
7	Nominated for participation and attendance in scientific conferences.	14.5	32.3	32.3	14.5	6.4	2.66	1.093	53.2	7
8	I was nominated for foreign scientific missions.	29.1	31.4	24.1	9.1	6.4	2.32	1.171	46.4	8
Overall average							2.80	0.832	56.0	

Table (4.7) showed that the highest score was in item “training contributes to the development of my professional performance” with mean score 3.11 and mean percent 62.2%, followed by “the administration follows up on the implementation of what has been achieved in the training process” with mean score 2.97 and mean percent 59.4%, while the lowest score was in “I was nominated for foreign scientific missions” with mean score 2.32 and mean percent 46.4%, followed by “Nominated for participation and attendance in scientific conferences” with mean score 2.66 and mean percent 53.2%. The overall mean

score was 2.80 and the mean percent was 56%. The hospital pay attention to development of physicians. *As stated by the medical director, "most of the doctors are enrolled in the Board program in subspecialties such as general surgery, internal medicine, Emergency medicine, and pediatrics."*

This result is inconsistent with the study conducted by (Abu Hasera, 2016) which found there was a low degree of approval by the sample members on the training paragraphs, and the highest percentage of approval was in the paragraph that talked about training's contributions to the development of my professional performance, with a percentage of 56.26%, and the a mean percent of overall was 47.01%. Moreover, the result is inconsistent with a study conducted by (Abu harbeed, 2021) that found in training paragraphs like this one, the hospital administration provides courses for regular training for healthcare providers with a rate of 49.78% and a paragraph of "I feel the need to take additional training to provide health services of higher quality" with a percentage of 66.90%. The result was a medium percentage of 56.0 % for the perception of healthcare providers about training. *As reported by the director of nursing, "the in-service training department play a major role in developing and improving the nurses' knowledge and skills. We have an educational plan, all the nurses received BLS training, all the nurses in ICU, Emergency Department, and CCU received training on ACLS."*

The researcher attributed the little approval of all the paragraphs of the field together to indicate the dissatisfaction of the working human cadre. From the level of concern for them as employees, the hospital administration must meet their needs for training periodically as well as contribute to their professional development by nominating them to participate in scientific fields and conferences and sending them abroad to hone their skills, increase their knowledge, and get more degrees, which leads to an increase in their affiliation with their work and dedication to serving the hospital and its recipients. It is also due to obtaining a low percentage in this field due to the lack of budgets for the government to send abroad, the lack of funding, the difficult economic situation, and the division between the two parts of the country.

Table (4.8): Workload and excessive working hours (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	A sufficient number of health service providers are available to ensure the provision of a good health service.	6.4	12.7	44.1	31.4	5.5	3.17	0.943	63.4	4
2	The hours are scheduled to ensure the provision of a good health service.	4.1	9.5	43.6	37.3	5.5	3.30	0.872	66.0	1
3	The number of working hours is proportional to the volume of services provided.	7.7	9.1	42.7	35.0	5.5	3.21	0.963	64.2	3
4	Employees' overtime hours are calculated.	16.4	7.3	38.2	33.6	4.5	3.03	1.118	60.6	5
5	Annual vacations are scheduled for employees in proportion to work conditions	8.6	7.7	43.2	34.1	6.4	3.22	0.987	64.4	2
Overall average							3.18	0.887	63.6	

Table (4.8) showed that the highest score was in item “the hours are scheduled to ensure the provision of a good health service” with mean score 3.30 and mean percent 66%, followed by “annual vacations are scheduled for employees in proportion to work conditions” with mean score 3.22 and mean percent 64.4%, while the lowest score was in “employees' overtime hours are calculated” with mean score 3.03 and mean percent 60.6%. The overall mean score was 3.18 and the mean percent was 63.6%. *As stated by the medical director, "there is a chronic shortage of staff (doctors and nurses), and we cover the shortage by overtime, but the doctors and nurses do not receive money or incentives for the extra hours they work. This condition increases the frustration of doctors and nurses, and it affects the quality of health care."*

This result is inconsistent with the study conducted by (Abu Hasera, 2016) which found a low a mean percent of 48.57% in the field of workload and excessive working hours. And the result is consistent with the study conducted by (Abu harbeed, 2021) which found a moderate mean percentage of 67.91% in the field of workload. The researcher attributed the medium's approval of all the paragraphs of the field together because no employees were appointed during the previous years. The severe shortage of health staff is filled by

volunteers and trainees, and this category is considered part of it, not qualified to the required degree, or with little experience, and this is a negative indication of the quality of services provided through the hospital and is due to a severe shortage in the budgets available for wages through the government. As the employees do not get paid, the basics are complete, let alone calculating the overtime hours, and this was confirmed by the key managers of the complex when they were interviewed, knowing that there were a large number of overtime hours for the category of doctors. Some of them are called for emergency surgeries, and nursing is also called for.

4.1.2.3 Responsive governance

Table (4.9): Management stands at the psychological, economic and social conditions of the worker (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	Management is concerned with supporting employees psychologically.	14.5	15.9	44.5	22.3	2.7	2.83	1.024	56.6	6
2	Management is concerned with supporting the employees socially.	15.9	11.8	46.8	22.7	2.7	2.85	1.035	57.0	5
3	Management is concerned with the way employees are dressed.	10.5	8.6	35.9	20.5	24.5	3.40	1.240	68.0	1
4	The management provides me with feedback on my professional performance and guides me on how to overcome the failure aspects, if happen.	11.4	20.5	45.0	20.5	2.7	2.83	0.973	56.6	7
5	Management sticks to its promises to employees.	13.6	12.7	47.3	21.8	4.5	2.91	1.034	58.2	4
6	Management appreciates the work I do and treats me with dignity and respect.	8.6	12.3	48.2	25.5	5.5	3.07	0.970	61.4	2
7	Management gives me the flexibility to change my shift after I have justified the reason for the change required.	9.5	10.0	50.5	25.9	4.1	3.05	0.952	61.0	3
Overall average							2.98	0.890	59.6	

Table (4.9) showed that the highest score was in item “management is concerned with the way employees are dressed” with mean score 3.40 and mean percent 68%, followed by “management appreciates the work I do and treats me with dignity and respect” with mean score 3.07 and mean percent 61.4%, while the lowest score was in “the management provides me with feedback on my professional performance and guides me on how to overcome the failure aspects, if happen” with mean score 2.83 and mean percent 56.6%, followed by “management is concerned with supporting employees psychologically” with mean score 2.83 and mean percent 56.6%. The overall mean score was 2.98 and the mean percent was 59.6%. *As stated by the general director of the complex, "there are permanent attempts to solve the problems related to the workers inside the complex from all psychological, economic, and social aspects. Still, there are many obstacles standing in front of us to achieve this goal, including the lack of funding to pay salaries and overtime, and the lack of staff as a result of the lack of employment, which would result in an increase in the workload of workers and an increase Physical and psychological pressures, as well as economic and social problems."*

This result is inconsistent with a study conducted by (Abu-Hassera, 2016) that found in the field of “management takes into account the psychological, economic, and social conditions of the workers.” There was little approval from the sample members on the parameters of this field with a mean percent of 44.04%. In the paragraph "management is concerned with the way employees are dressed," there was a low agreement of 47.13%, and in "management appreciates the work I do and treats me with dignity and respect," there was a low agreement rate of 43.98%.

Table (4.10): Availability of medication and medical supplies (n= 220)

No.	Item	Very low extent	Low extent	Moderate extent	High extent	Very high extent	Mean	SD	%	Rank
1	The basic medicines needed to treat different conditions are available in the pharmacy.	2.7	33.6	52.3	8.6	2.7	2.75	0.762	55.0	3
2	The non-essential medicines needed to treat different conditions are available in the pharmacy.	5.5	36.4	51.8	4.5	1.8	2.61	0.741	52.2	5
3	Medical supplies are provided in quantities commensurate with the number of service recipients.	4.1	35.5	52.7	6.4	1.4	2.65	0.721	53.0	4
4	Medicines are provided to patients in the departments through a single dose system every 24 hours (Kardex).	2.3	30.0	50.0	10.0	7.7	2.91	0.892	58.2	1
5	Medical supplies are provided on written orders.	1.8	30.9	51.8	9.1	6.4	2.87	0.845	57.4	2
6	There is a permanent stock of medicines and medical supplies within the stock sections.	7.3	36.8	47.7	5.0	3.2	2.60	0.824	52.0	6
Overall average							2.73	0.663	54.6	

Table (4.10) showed that the highest score was in item “medicines are provided to patients in the departments through a single dose system every 24 hours (Kardex)” with mean score 2.91 and mean percent 58.2%, followed by “medical supplies are provided on written orders” with mean score 2.87 and mean percent 57.4%, while the lowest score was in “there is a permanent stock of medicines and medical supplies within the stock sections” with mean score 2.60 and mean percent 52%, followed by “the non-essential medicines needed to treat different conditions are available in the pharmacy” with mean score 2.61 and mean percent 52.2%. The overall mean score was 2.73 and the mean percent was 54.6%. *As stated by the director of nursing, "there is a shortage in supplies, and some consumables are not available. Therefore, we have to find alternatives especially in medication."*

This result is consistent with a study conducted by (Abu-Hassera, 2016) that found there is a degree of approval Average by the respondents a low mean percent of 51.12% in the field of Availability of medication and medical supplies. And this result is inconsistent with a study conducted by (Abu harbeed, 2021) that found the hospital has the necessary medicines for patients with a mean percent of 70.21%. The researcher explains that all the paragraphs of the field together obtained a low degree of approval until the Ministry of Health provides medicines and medical supplies to 13 hospitals and 52 primary care centers, and these facilities need very large quantities of medicines and supplies; This constitutes a burden on the budgets of the Ministry of Health in light of siege and division, where the necessary funding is provided to purchase any supplies, whether medicines or any other supplies, through separate money transfers irregular, or the necessary is transferred from the Ministry of Health in Ramallah and international donors, and medicines are provided and stored in the warehouses of the General Administration of Pharmacy, and then given Each facility of the Ministry of Health has its share of medicines and supplies according to the monthly statistics; but relatively according to availability; Where it divides what is available on all health facilities.

Table (4.11): Overall quality of health services in the hospital (n= 220)

Domain	Mean	SD	%
Clinical effectiveness of health services	2.88	0.421	57.6
- Infrastructure and work environment	2.64	0.592	52.8
- Return to ICU	3.08	0.536	61.6
- Prophylactic antibiotic availability and use	2.91	0.654	58.2
Staff orientation and safety	3.10	0.648	62.0
- Work-related injuries	3.32	0.810	66.4
- Training	2.80	0.832	56.0
- Workload and excessive working hours	3.18	0.887	63.6
Responsive governance	2.86	0.574	57.2
- Management stands at the psychological, economic and social conditions of the worker	2.98	0.890	59.6
- Availability of medication and medical supplies	2.73	0.663	54.6
Overall quality of health services	2.88	0.423	57.6

Table (4.11) presented the results of each domain and the overall quality of health services. The results showed that the highest score was in the domain of staff orientation and safety with mean score 3.10 and mean percent 62% which indicated moderate level of quality in this domain. The second domain was clinical effectiveness of health services with mean score 2.88 and mean percent 57.6% which indicated moderate level of quality in this domain. The third domain was responsive governance with mean score 2.86 and mean percent 57.2% which indicated moderate level of quality in this domain. The overall mean score was 2.88 and the mean percent was 57.6% which indicated that the health care providers perceived that the quality of health services provided at Al Shifa Medical complex was at moderate level. This result is inconsistent with a study conducted by (F. Al-Jabri et al., 2021) that found healthcare professionals rated the quality of treatment and patient safety as excellent. *As stated by the medical director, "we are focusing on the quality of health care services, we put standards and protocols for most of the interventions and treatment programs. The staff is adequately competent, and Al Shifa Medical Complex is considered a referral hospital, receiving patients from other hospitals. Sometimes, we face a problem of shortage of beds in the medical department because the old building has been demolished, and we are waiting for the construction of a new building for the medical departments. Also, we are going to improve the function of emergency services, and now, there is a plan to expand the ED to 50 beds with 8 beds for critical care."*

4.1.3 Differences in perception about quality of health services related to sociodemographic characteristics of health care providers

Table (4.12): Differences in perception about quality of health services related to gender

Variable	Gender	n	Mean	SD	t	P value
Clinical effectiveness of health services	Male	147	2.861	0.414	-1.092	0.276
	Female	73	2.927	0.436		
Staff orientation and safety	Male	147	3.155	0.683	1.619	0.107
	Female	73	3.005	0.563		
Responsive governance	Male	147	2.875	0.592	0.525	0.600
	Female	73	2.832	0.540		
Overall quality of health services	Male	147	2.899	0.436	0.588	0.557
	Female	73	2.863	0.397		

Table (4.12) showed that there were statistically no significant differences in perception about quality of health services between male and female healthcare providers in all the domains and the overall quality of health services provided ($P= 0.557$).

Table (4.13a): Differences in perception about quality of health services related to age

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	1.339	2	0.669	3.857	0.023 *
	Within Groups	37.651	217	0.174		
	Total	38.990	219			
Staff orientation and safety	Between Groups	7.565	2	3.783	9.709	0.000 *
	Within Groups	84.544	217	0.390		
	Total	92.109	219			
Responsive governance	Between Groups	2.225	2	1.113	3.443	0.034 *
	Within Groups	70.141	217	0.323		
	Total	72.367	219			
Overall quality of health services	Between Groups	1.508	2	0.754	4.342	0.014 *
	Within Groups	37.697	217	0.174		
	Total	39.206	219			

*Significant at 0.05

Table (4.13a) showed that there were statistically significant differences in all the domains and the overall perception about quality of health services related to age of health care providers ($P= 0.014$). To find out the direction of these differences, the researcher performed Post hoc LSD test as shown in table (4.13b).

Table (4.13b): Significance of the differences in perception about quality of health services related to age (LSD test)

Variable	Age group		Mean Difference	P value
Clinical effectiveness of health services	≤ 30 years	31-40 years	0.189	0.012 *
		41 years and more	0.061	0.524
Staff orientation and safety	≤ 30 years	31-40 years	-0.292	0.010 *
		41 years and more	-0.635	0.000 *
Responsive governance	≤ 30 years	31-40 years	-0.215	0.037 *
		41 years and more	-0.332	0.012 *
Overall quality of health services	≥ 41 years	30 years and less	0.242	0.012 *
		31-40 years	0.216	0.006 *

*Significant at 0.05

Table (4.13b) showed that health care providers from the age group 30 years old and less have significantly higher perception about the quality of clinical effectiveness of health services compared to health care providers from the age group 31 – 40 years ($P= 0.012$), while the differences were insignificant with the age group 41 years and older ($P= 0.524$). In addition, health care providers from the age group 30 years and less expressed significantly lower perception about the quality of staff orientation and safety compared to health care providers from the age group 31 – 40 years ($P= 0.010$) and those from the age group 41 years and older ($P= 0.000$). Moreover, health care providers from the age group 30 years and less showed significantly lower perception about the quality of responsive governance compared to health care providers from the age group 31 – 40 years ($P= 0.037$) and those from the age group 41 years and older ($P= 0.012$). in general, health care providers who are 41 years and older expressed significantly higher perception about the overall quality of health services compared to health care providers from the age group 30 years and less ($P= 0.012$) and health care providers from the age group 31 – 40 years ($P= 0.006$). The researcher attributes that health care providers who are 41 years and older express significantly higher perceptions about the overall quality of health services as the result of experience, training , qualification and make them more efficient to use devices and tools, and better able to deal with the different types of people that frequent them during providing them with the services required of them, whereas health care providers from the age group 30 years and less showed significantly lower perceptions about the overall quality of health

services and it's the result from the lack of sufficient competence and experience for health service providers who are less than 30 years old to judge the quality of services. Weakness in terms of working on training these people Employees and their continuity of development, and do not take their suggestions effectively, and the other reason is also the dissatisfaction of the provider's health services about the salaries and wages they receive, and the researcher attributes this to the financial crisis The Palestinian government suffers, and the salaries are not being paid regularly and appropriately their tasks, the work pressure they are exposed to, and the low level of job satisfaction among employers Health Services.

Table (4.14): Differences in perception about quality of health services related to marital status

Variable	Marital status	n	Mean	SD	t	P value
Clinical effectiveness of health services	Married	191	2.870	0.407	-1.142	0.255
	Unmarried	29	2.966	0.509		
Staff orientation and safety	Married	191	3.137	0.631	1.896	0.059
	Unmarried	29	2.894	0.727		
Responsive governance	Married	191	2.849	0.569	-0.785	0.433
	Unmarried	29	2.939	0.614		
Overall quality of health services	Married	191	2.889	0.408	0.202	0.840
	Unmarried	29	2.872	0.517		

Table (4.14) showed that there were statistically no significant differences in perception about quality of health services related to marital status of healthcare providers in all the domains and the overall quality of health services provided ($P= 0.840$).The researcher attributes the absence of differences in perception of the quality of health services based on marital status for healthcare providers across all domains and the overall quality of health services provided at Al-Shifa Medical Complex to the fact that healthcare providers work under the same professional and social conditions, regulations, and laws.

Table (4.15): Differences in perception about quality of health services related to qualification

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	0.452	3	0.151	0.844	0.471
	Within Groups	38.538	216	0.178		
	Total	38.990	219			
Staff orientation and safety	Between Groups	2.299	3	0.766	1.843	0.140
	Within Groups	89.811	216	0.416		
	Total	92.109	219			
Responsive governance	Between Groups	0.431	3	0.144	0.431	0.731
	Within Groups	71.936	216	0.333		
	Total	72.367	219			
Overall quality of health services	Between Groups	0.636	3	0.212	1.187	0.315
	Within Groups	38.570	216	0.179		
	Total	39.206	219			

Table (4.15) showed that there were statistically no significant differences in perception about quality of health services related to qualification of healthcare providers in all the domains and the overall quality of health services provided ($P= 0.315$). The researcher attributes the absence of differences in perception about the quality of health services related to the qualification of healthcare providers in all the domains and the overall quality of health services provided because healthcare providers with scientific qualifications provide health services at the same level and work in the same professional conditions.

Table (4.16): Differences in perception about quality of health services related to specialty

Variable	Specialty	N	Mean	SD	t	P value
Clinical effectiveness of health services	Physician	129	2.845	0.388	-1.612	0.108
	Nurse	91	2.937	0.461		
Staff orientation and safety	Physician	129	3.165	0.703	1.646	0.101
	Nurse	91	3.020	0.554		
Responsive governance	Physician	129	2.883	0.537	0.674	0.501
	Nurse	91	2.829	0.625		
Overall quality of health services	Physician	129	2.890	0.425	0.138	0.890
	Nurse	91	2.882	0.421		

Table (4.16) showed that there were statistically no significant differences in perception about quality of health services related to specialty of healthcare providers in all the domains and the overall quality of health services provided ($P= 0.890$).

Table (4.17a): Differences in perception about quality of health services related to job position

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	0.664	2	0.332	1.880	0.155
	Within Groups	38.326	217	0.177		
	Total	38.990	219			
Staff orientation and safety	Between Groups	10.427	2	5.213	13.850	0.000 *
	Within Groups	81.682	217	0.376		
	Total	92.109	219			
Responsive governance	Between Groups	1.692	2	0.846	2.597	0.077
	Within Groups	70.675	217	0.326		
	Total	72.367	219			
Overall quality of health services	Between Groups	2.986	2	1.493	8.944	0.000 *
	Within Groups	36.220	217	0.167		
	Total	39.206	219			

*Significant at 0.05

Table (4.17a) showed that there were statistically no significant differences in perception about quality of health services related to qualification of healthcare providers in the clinical effectiveness of health services domain ($P= 0.155$) and the responsive governance domain ($P= 0.077$), while significant differences existed in staff orientation and safety domain ($P= 0.000$) and the overall quality of health services ($P= 0.000$). To find out the direction of these differences, the researcher performed Post hoc LSD test as presented in table (4.17b).

Table (4.17b): Significance of the differences in perception about quality of health services related to job position (LSD test)

Variable	Job title		Mean Difference	P value
Staff orientation and safety	Subordinate	Head of division	-0.615	0.000 *
		Head of department	-0.391	0.003 *
Overall quality of health services	Subordinate	Head of division	-0.301	0.001 *
		Head of department	-0.251	0.005 *

*Significant at 0.05

Table (4.17b) showed that subordinates have significantly lower perception about quality of staff orientation and safety compared to head of divisions ($P= 0.000$) and head of departments ($P= 0.003$). Also, subordinates showed significantly lower perception about overall quality of health services compared to head of divisions ($P= 0.001$) and head of departments ($P= 0.005$). The researcher attributes that subordinates showed a significantly lower perception of the overall quality of health services compared to heads of divisions and heads of departments and given different opinions on service quality due to the particular roles, knowledge and information access, and in general different information on the hospital quality due to their level of specialization, earlier experience, and the varying hierarchical distance from the actual operational health service process. Moreover, the heads of divisions and heads of departments might have higher empowerment to deal with quality issues compared to other employee groups.

Table (4.18): Differences in perception about quality of health services related to department (Medical – surgical)

Variable	Department	n	Mean	SD	t	P value
Clinical effectiveness of health services	Medical	51	2.969	0.424	1.673	0.096
	Surgical	169	2.857	0.418		
Staff orientation and safety	Medical	51	3.239	0.488	2.026	0.045 *
	Surgical	169	3.064	0.685		
Responsive governance	Medical	51	2.925	0.387	1.166	0.246
	Surgical	169	2.841	0.620		
Overall quality of health services	Medical	51	2.990	0.359	2.210	0.029 *
	Surgical	169	2.856	0.436		

*Significant at 0.05

Table (4.18) showed that there were statistically no significant differences in perception about quality of health services between healthcare providers from medical departments and surgical departments in the clinical effectiveness of health services domain ($P= 0.096$) and the responsive governance domain ($P= 0.246$). In the other hand, health care providers from medical departments showed significant differences in staff orientation and safety domain ($P= 0.045$) and the overall quality of health services ($P= 0.029$) compared to health care providers from surgical departments.

The researcher attributes that health care providers from medical departments showed significant differences in staff orientation and safety domain and the overall quality of health services compared to health care providers from surgical departments. The level of safety available in the hospital is the same for all employees and the reception of difficult and incurable cases referred to the hospital from the rest of the hospitals that provide similar services, overburdening the workers by increasing the working hours without any financial return to cover the shortage in the number of workers and the poor condition of the building and the lack of space; So that it is not commensurate with the workload and the number of auditors, and also - the weak role of maintenance in performing preventive maintenance for devices and buildings; To preserve and prolong its age, and the improvement of the services provided through it; to ensure the quality of the results issued by these devices, the services provided in the hospital are not computerized.

In addition, the lack of beds and the absence of a building for medical diseases, the removal of the buildings of the medical Hospital, which was on the verge of collapse, and evacuating sections and distributing the medical departments to the other buildings of the complex; And due to the lack of modern equipment, tools, supplies and special places available to provide private health services as well the number of patients has not decreased and has increased significantly, and also due to the presence of the Covid 19 pandemic, which led to the filling of the departments, which put more pressure on the existing departments and on the ability of the staff to deal with them. It is known that cases of internal diseases require a longer stay within the internal departments. The increase in the number of cases referred to the hospital is due to the difficult economic situation in which living the peoples of the Gaza Strip during the previous years suffered from the siege, closures, and internal division, and directed them to government hospitals and not to private hospitals. The above mention interpretation was confirmed by the key managers when they were interviewed. *As stated by the general director " we face a problem of shortage of beds in the medical department because the old building has been demolished, and we are waiting for the construction of a new building for the medical departments. Also, there was a blockade imposed on the Gaza Strip 15 years ago that hindered the provision of some health services, supplies, and medical equipment, but we always strive to provide the service appropriately as possible".*

Table (4.19a): Differences in perception about quality of health services related to experience in the hospital

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	0.570	3	0.190	1.069	0.363
	Within Groups	38.420	216	0.178		
	Total	38.990	219			
Staff orientation and safety	Between Groups	7.069	3	2.356	5.985	0.001 *
	Within Groups	85.041	216	0.394		
	Total	92.109	219			
Responsive governance	Between Groups	0.953	3	0.318	0.961	0.412
	Within Groups	71.414	216	0.331		
	Total	72.367	219			
Overall quality of health services	Between Groups	0.926	3	0.309	1.741	0.160
	Within Groups	38.280	216	0.177		
	Total	39.206	219			

*Significant at 0.05

Table (4.19a) showed that there were statistically no significant differences in perception about quality of health services related to healthcare providers' experience in the hospital in all the domains and the overall quality of health services provided ($P = 0.160$), while there were significant differences in staff orientation and safety domain ($P = 0.001$). To find the direction of these differences, the researcher performed Post hoc LSD test as shown in table (4.19b).

Table (4.19b): Significance of the differences in perception about quality of health services related to experience in the hospital (LSD test)

Variable	Experience in the hospital		Mean Difference	P value
Staff orientation and safety	≤ 5 years	6 – 10 years	-0.289	0.019 *
		11 – 15 years	-0.372	0.003
		≥ 16 years	-0.601	0.000 *

*Significant at 0.05

Table (4.19b) showed that health care providers with 5 years of experience and less expressed significant lower perception about quality of staff orientation and safety compared to health care providers with 6 – 10 years of experience ($P= 0.019$) and health care providers with an experience of 16 years and more ($P= 0.000$). The researcher attributes that healthcare providers with 5 years of experience and less expressed significantly lower perceptions about the quality of staff orientation and safety compared to healthcare providers with 6 – 10 years of experience and healthcare providers with an experience of 16 years and more because it also shows the dissatisfaction with the provider's Health services, given the work pressure they are exposed to in the first years of their work and their lack of job experience, as well as the low salaries and wages they receive , and also due to the lack of experience among some of the workers from the internship doctors, first doctors the general public, as well as the doctors and nurses who are hired on the contract or unemployment clause to fill the shortage in the human cadre, so how about calculating the overtime hours, knowing that there are a large number of workers Overtime hours for the category of doctors; And nursing, where some of them are called to perform emergency surgeries, as well as nursing to cover work periods due to the pressure that exists.

Table (4.20a): Differences in perception about quality of health services related to experience in the department

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	0.365	3	0.122	0.679	0.565
	Within Groups	38.625	216	0.179		
	Total	38.990	219			
Staff orientation and safety	Between Groups	9.751	3	3.250	8.525	0.000 *
	Within Groups	82.358	216	0.381		
	Total	92.109	219			
Responsive governance	Between Groups	1.168	3	0.389	1.182	0.318
	Within Groups	71.199	216	0.330		
	Total	72.367	219			
Overall quality of health services	Between Groups	0.855	3	0.285	1.606	0.189
	Within Groups	38.350	216	0.178		
	Total	39.206	219			

*Significant at 0.05

Table (4.20a) showed that there were statistically no significant differences in perception about quality of health services related to healthcare providers' experience in the department in all the domains and the overall quality of health services provided ($P= 0.189$), while there were significant differences in staff orientation and safety domain ($P= 0.000$). To find the direction of these differences, the researcher performed Post hoc LSD test as shown in table (4.20b).

Table (4.20b): Significance of the differences in perception about quality of health services related to experience in the department (LSD test)

Variable	Experience in the department		Mean Difference	P value
Staff orientation and safety	≤ 5 years	6 – 10 years	-0.401	0.000 *
		11 – 15 years	-0.363	0.001 *
		≥ 16 years	-0.652	0.000 *

*Significant at 0.05

Table (4.20b) showed that health care providers with 5 years of experience and less expressed significant lower perception about quality of staff orientation and safety compared to health care providers with 6 – 10 years of experience ($P= 0.000$), health care providers with 11 – 15 years of experience ($P= 0.001$), and health care providers with an experience of 16 years and more ($P= 0.000$). The researcher attributes that healthcare providers with showed that health care providers with 5 years of experience and less expressed significant lower perceptions about the quality of staff orientation and safety compared to healthcare providers with 6 – 10 years of experience, healthcare providers with 11 – 15 years of experience and health care providers with an experience of 16 years and more its results from the lack of courses and training within the complex, as well as the lack of experience that the employee cannot access until after several years to gain extensive experience and different skills that enable him to how to deal with different cases and protect himself from contracting any expected diseases at work and how to avoid them and his inability to obtain studies Specialized and postgraduate studies that increase its scientific and practical ability to develop itself, which results in the inability to adapt and deal in an appropriate and required manner. Also, the excessive burden of working hours may be another factor that makes the employee not work as required and with high efficiency and gives a vague perception of the quality of health services.

Table (4.21a): Differences in perception about quality of health services related to income

Variable		Sum of Squares	df	Mean Square	F	P value
Clinical effectiveness of health services	Between Groups	0.207	3	0.069	0.385	0.764
	Within Groups	38.783	216	0.180		
	Total	38.990	219			
Staff orientation and safety	Between Groups	11.093	3	3.698	9.858	0.000 *
	Within Groups	81.017	216	0.375		
	Total	92.109	219			
Responsive governance	Between Groups	1.755	3	0.585	1.789	0.150
	Within Groups	70.612	216	0.327		
	Total	72.367	219			
Overall quality of health services	Between Groups	2.768	3	0.923	5.469	0.001 *
	Within Groups	36.438	216	0.169		
	Total	39.206	219			

*Significant at 0.05

Table (4.21a) showed that there were statistically no significant differences in perception about quality of health services related to income of healthcare providers in the clinical effectiveness of health services domain ($P= 0.764$) and the responsive governance domain ($P= 0.150$), while significant differences existed in staff orientation and safety domain ($P= 0.000$) and the overall quality of health services ($P= 0.001$). To find out the direction of these differences, the researcher performed Post hoc LSD test as presented in table (4.21b).

Table (4.21b): Significance of the differences in perception about quality of health services related to income (LSD test)

Variable	Experience in the department		Mean Difference	P value
Staff orientation and safety	≤ 1800 NIS	1801 – 2400 NIS	-0.221	0.082
		2500 – 3000 NIS	-0.499	0.000 *
		> 3000 NIS	-0.484	0.000 *

*Significant at 0.05

Table (4.21b) showed that health care providers who have an income of 1800 NIS and less showed significant lower perception about quality of staff orientation and safety compared to health care providers who have an income of 2500 – 3000 NIS ($P= 0.000$), and health care providers who have an income of more than 3000 NIS ($P= 0.000$).

The researcher attributes that healthcare providers who have an income of 1800 NIS and less showed a significantly lower perception of quality of staff orientation and safety compared to healthcare providers who have an income of 2500 - 3000 NIS and healthcare providers who have an income of more than 3000 NIS and this came as a result of the different conditions in which this category of employees lives through the volatile conditions of the financial and economic crisis what hospitals and the ministry of health suffer from, and the general conditions surrounding the sector are what cause not disbursing salaries regularly and in proportion to their tasks, the work pressure they are exposed and the extra hours that are not spent, which puts them in financial hardship compared to the high standard of living within the sector and the low level of job satisfaction among employers.

The health services in the hospital come from the lack of interest in the staff by the hospital administration, the lack of security and job satisfaction among the health staff, and the aforementioned category that works under pressure, the lack of the number of health staff, and the siege imposed on the sector and the ministry of health is required to work on regularity and improvement of salaries and incentives, as well as providing training courses for the development and development of the medical staff.

4.1.4 Perception about the hospital

Table (4.22): Perception rating of the hospital (n= 220)

No.	Item	Mean	SD	%	Rank
1	Management response to the professional needs of employees	5.76	1.987	57.6	7
2	Work system inside the complex	5.76	1.746	57.6	8
3	Devices and tools in the complex.	5.85	1.610	58.5	5
4	Availability of medications inside the complex.	5.99	1.435	59.9	4
5	The level of cleanliness inside the complex.	8.10	1.630	81.0	1

Table (4.22): Continued

No.	Item	Mean	SD	%	Rank
6	The external hospital design is suitable for providing health services.	5.80	1.838	58.0	6
7	The hospital interior design is suitable for providing health services.	5.40	1.756	54.0	9
8	Availability of resting places for employees.	4.88	2.021	48.8	12
9	Availability of waiting areas for patients within the complex.	4.77	1.881	47.7	14
10	Instruction and instruction boards are available in all areas of the complex	7.10	2.250	71.0	3
11	commitment to written appointments to visit patients inside the complex.	5.26	2.272	52.6	10
12	Availability of security personnel in the needed places within the complex	7.30	2.514	73.0	2
13	The presence of places for cars parking	4.80	1.789	48.0	13
14	The presence of sufficient gardens within hospital premises	4.73	1.640	47.3	15
15	The members of the complex participate in the public and community events and activities	4.90	1.927	49.0	11
Overall average		5.76	1.168	57.6	

Table (4.22) the rating of the hospital by the health care providers. The results showed that the highest rate was in “the level of cleanliness inside the complex” (81%), followed by “availability of security personnel in the needed places within the complex” (73%), and “instruction and instruction boards are available in all areas of the complex” (P= 71%). The lowest rating was in “the presence of sufficient gardens within hospital premises” (47.3%), followed by “availability of waiting areas for patients within the complex” (47.7%). The overall mean score was 5.76 out of 10, and the mean percent was 57.6%, which indicated that the health care providers rated the hospital health services at moderate level. This result is inconsistent with the study conducted by (Abu Hasera, 2016) who found the item "The level of cleanliness inside the complex "is low with a percentage of 46.61%, and the item of "Availability of medications inside the complex" is low with the percentage of 49.14% in addition to the item of "Devices and tools in the complex" is very low with the percentage of 45.11%. Moreover, all items about hospital perception from healthcare providers have a low mean percentage which indicated that the healthcare providers rated the hospital health services at a low level. The researcher attributes that the item "The level of cleanliness inside the complex" takes the highest percentage because these facilities are cleaned Every 3 hours at least, using cleaning materials with a certain concentration, according to the contract

concluded between the Ministry and the cleaning company that was awarded the hygiene contract for Al-Shifa Medical Complex; where has been privatized Hygiene services have been provided in all Ministry of Health facilities for years, and the item of "Availability of security personnel in the needed places within the complex" has also taken a high rate due to the provision of elements of security in all departments of the hospital and at its gates to maintain security due to the presence of many attacks on medical staff and also to maintain security and control the freedom of work of employees without hindrance. In addition the item " The presence of sufficient gardens within hospital premises" and item of "Availability of waiting areas for patients within the complex" took a low mean percentage because the Ministry of Health has built many buildings and departments in the place of these gardens and the area of the complex as it is and did not expand, and also the lack of waiting for places for patients due to the old design of some buildings inside the complex, which does not allow patients to find places to rest and wait and due to the small size of these buildings and the large number of patients who visit the Complex hospitals.

Satisfaction of employees in this field with a moderate level percentage. means that the performance of the hospital and the services provided there is good, and this point is calculated for the employees; Where who always aspire for the better, for improvement and development, and on the other hand, it is calculated by the administration, as it does not provide them with what they ask for or what they need; Which increases their affiliation with the hospital, makes them more tender and increases their productive capacity for services provided in the hospital.

4.2 Patients' part

4.2.1 Sociodemographic characteristics of patients

The study sample consisted of 175 patients (58 from medical and 117 surgical departments at Al Shifa hospital. Their characteristics are illustrated below.

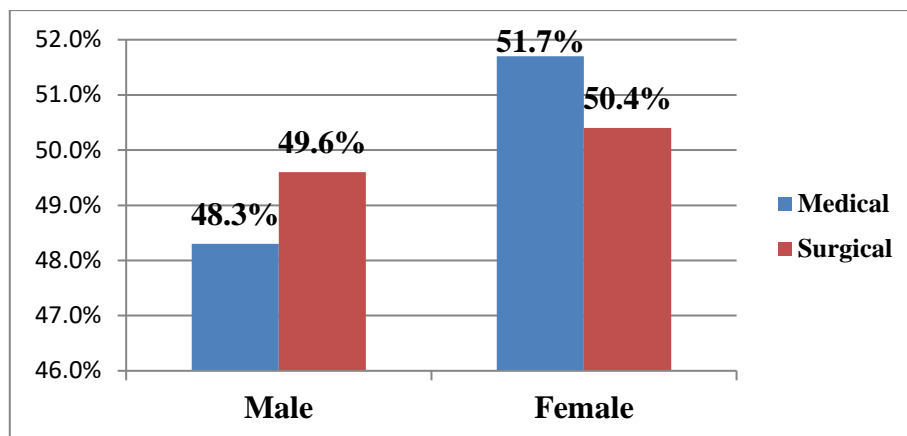


Figure (4.1): Distribution of study participants by gender and department

Figure (4.1) showed that the number of participants from medical departments was 58 patients; 28 (48.3%) were male patients and 30 (51.7%) were female patients. Also, the number of participants from surgical departments was 117 patients; 58 (49.6%) were male patients and 59 (50.4%) were female patients.

Table (4.23a): Distribution of patients by sociodemographic characteristics (n= 175)

Variable	Category	Medical Dept. n (%)	Surgical Dept. n (%)	Total n (%)
Age	≤ 20 years	5 (8.6)	11 (9.4)	16 (9.1)
	21 – 30 years	8 (13.8)	21 (17.9)	29 (16.6)
	31 – 40 years	21 (36.2)	50 (42.7)	71 (40.6)
	41 – 50 years	13 (22.4)	17 (14.5)	30 (17.1)
	≥ 51 years	11 (19.0)	18 (15.4)	29 (16.6)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
	Mean= 38.90, SD= 13.453 years			
Marital status	Single	8 (13.8)	32 (27.4)	40 (22.9)
	Married	37 (63.8)	72 (61.5)	109 (62.3)
	Divorced	7 (12.1)	5 (4.3)	12 (6.9)
	Widow	6 (10.3)	8 (6.8)	14 (8.0)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Place of residency	Gaza	14 (24.1)	48 (41.0)	62 (35.4)
	North	25 (43.1)	31 (26.5)	56 (32.0)
	Middle	11 (19.0)	28 (23.9)	39 (22.3)
	Khanyounis	5 (8.6)	10 (8.5)	15 (8.6)
	Rafah	3 (5.2)	0 (0)	3 (1.7)
	Total	58 (100.0)	117 (100.0)	175 (100.0)

Table (4.23a) showed that 21 (36.2%) of patients from medical departments and 50 (42.7%) of patients from surgical departments aged between 31 – 40 years old, with mean age 38.9 years. The results also showed that 37 (63.8%) of patients from medical departments and 72 (61.5%) of patients from surgical departments were married. In addition, 14 (24.1%) of patients from medical departments and 48 (41%) of patients from surgical departments were from Gaza governorate, and 25 (43.1%) of patients from medical departments and 31 (26.5%) of patient from surgical departments were from the North governorate.

Table (4.23b): Distribution of patients by sociodemographic characteristics (n= 175)

Variable	Category	Medical Dept. n (%)	Surgical Dept. n (%)	Total n (%)
Citizenship	Refugee	51 (87.9)	89 (76.1)	140 (80.0)
	Citizen	7 (12.1)	28 (23.9)	35 (20.0)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Level of education	Primary school	10 (17.2)	9 (7.7)	19 (10.9)
	Prep school	10 (17.2)	22 (18.8)	32 (18.3)
	Secondary school	24 (41.4)	45 (38.5)	69 (39.4)
	University	14 (24.1)	41 (35.0)	55 (31.4)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Job	Not working	35 (60.3)	69 (59.0)	104 (59.4)
	Employee	18 (31.0)	38 (32.5)	56 (32.0)
	Free business	5 (8.6)	10 (8.5)	15 (8.6)
	Total	58 (100.0)	117 (100.0)	175 (100.0)

Table (4.23b) showed that 51 (87.9%) of patients from medical departments and 89 (76.1%) of patients from surgical departments were refugees, 24 (41.4%) of patients from medical departments and 45 (38.5%) of patients from surgical departments have secondary education, and 14 (24.1%) of patients from medical departments and 41 (35%) of patients from surgical departments have university education. In addition, 35 (60.3%) of patients from medical departments and 69 (59%) of patients from surgical departments were not working, while 18 (31%) of patients from medical departments and 38 (32.5%) of patient from surgical departments were employees.

The researcher believed that most patients in the medical and surgical departments are refugees, this result is expected because they constitute 66% of the total population in Gaza Strip (UNRWA, 2021b). Mainly the refugees people access the governmental hospitals because it provides free-of-pay healthcare services. Furthermore, the result showed that 60.3% of patients from medical departments and 59% of patients from surgical departments are not working, while 31% of patients from medical departments and 32.5% of patients from surgical departments were employees, it all goes back to the high rate of unemployment and deteriorating conditions in Gaza Strip.

Table (4.24a): Distribution of patients by illness-related information (n= 175)

Variable	Category	Medical Dept. n (%)	Surgical Dept. n (%)	Total n (%)
Method of payment	Private insurance	8 (13.8)	21 (17.9)	29 (16.6)
	Governmental insurance	41 (70.7)	76 (65.0)	117 (66.9)
	Military insurance	5 (8.6)	13 (11.1)	18 (10.3)
	Social affairs insurance	2 (3.4)	5 (4.3)	7 (4.0)
	Self-pay	2 (3.4)	2 (1.7)	4 (2.3)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
First time admission	No	16 (27.6)	26 (22.2)	42 (24.0)
	Yes	42 (72.4)	91 (77.8)	133 (76.0)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Number of admissions	One time	42 (72.4)	91 (77.8)	133 (76.0)
	2 – 3 times	8 (13.8)	12 (10.3)	20 (11.4)
	4 times and more	8 (13.8)	14 (12.0)	22 (12.6)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Mode of admission	Emergency	25 (43.1)	71 (60.7)	96 (54.9)
	OPD	24 (41.4)	34 (29.1)	58 (33.1)
	Referred from private clinic	9 (15.5)	12 (10.3)	21 (12.0)
	Total	58 (100.0)	117 (100.0)	175 (100.0)

Table (4.24a) showed that 41 (70.7%) of patients from medical departments and 76 (65%) of patients from surgical departments have governmental medical insurance. Also, 42 (72.4%) of patients from medical departments and 91 (77.8%) of patients from surgical

departments admitted to the hospital for the first time, while 8 (13.8%) of patients from medical departments and 12 (10.3%) of patients from surgical departments have been admitted 2 – 3 times, 8 (13.8%) of patients from medical departments and 14 (12%) of patients from surgical departments have been admitted for 4 times and more. The results also showed that 25 (43.1%) of patients from medical departments and 71 (60.7%) of patients from surgical departments were admitted through emergency department, 24 (41.4%) of patient from medical departments and 34 (29.1%) of patients from surgical departments were admitted through the out-patient department, while 9 (15.5%) of patients from medical departments and 12 (10.3%) of patients from surgical departments were referred from private clinics. The researcher estimated that 70.7% of patients from medical departments and 65% of patients from surgical departments have governmental health insurance. This indicates that the vast majority of patients in this study committed to obtaining health care at governmental hospitals especially it provides preventive, diagnostic, curative and rehabilitated care. Furthermore, more inpatients were admitted for the first time, thus indicating a positive indicator for the readmission rate at AlShifa Medical Complex.

Table (4.24b): Distribution of patients by illness-related information (n= 175)

Variable	Category	Medical Dept.	Surgical Dept.	Total
		n (%)	n (%)	n (%)
Length of stay in the hospital	1 – 3 days	10 (17.2)	9 (7.7)	19 (10.9)
	4 – 6 days	31 (53.4)	69 (59.0)	100 (57.1)
	7 – 9 days	13 (22.4)	22 (18.8)	35 (20.0)
	10 days and more	4 (6.9)	17 (14.5)	21 (12.0)
	Total	58 (100.0)	117 (100.0)	175 (100.0)
Evaluation of health status	Bad	0 (0)	5 (4.3)	5 (2.9)
	Fair	2 (3.4)	4 (3.4)	6 (3.4)
	Good	13 (22.4)	31 (26.5)	44 (25.1)
	Very good	31 (53.4)	52 (44.4)	83 (47.4)
	Excellent	12 (20.7)	25 (21.4)	37 (21.1)
	Total	58 (100.0)	117 (100.0)	175 (100.0)

Table (4.24b) showed that 31 (53.4%) of patients from medical departments and 69 (59%) of patients from surgical departments stayed in the hospital for 4 – 6 days, 13 (22.4%) of patients from medical departments and 22 (18.8%) of patients from surgical departments stayed in the hospital for 7 – 9 days. In addition, 12 (20.7%) of patients from medical

departments and 25 (21.4%) of patients from surgical departments stated that their health status was excellent, 31 (53.4%) of patients from medical departments and 52 (44.4%) of patients from surgical departments stated that their health status was very good, while 5 (4.3%) of patients from surgical departments stated that their health status was bad.

Table (4.25): Information about surgery for patients from surgical department (n= 117)

Variable	Category	n	%
Postponed surgery	No	107	91.5
	Yes	10	8.5
	Total	117	100.0
Frequency of postponing surgery	None	107	91.5
	One time	4	3.4
	Two times	5	4.3
	Three times	1	0.9
	Total	117	100.0
Developed complications	No	102	87.2
	Yes	15	12.8
	Total	117	100.0
Type of complication	No complication	102	87.2
	Wound infection	11	9.4
	Obstruction of blood vessel	1	0.9
	A hole in duodenum	1	0.9
	Fever	1	0.9
	Another surgery done	1	0.9
	Total	117	100.0

Table (4.25) showed that 107 (91.5%) of patients from the surgical departments have their surgery done on time, while 10 (8.5%) of patients said that their surgery was postponed, of them 4 (3.4%) said that their surgery was postponed one time, 5 (4.3%) said that their surgery was postponed two times, and 1 (0.9%) said that their surgery was postponed three times. In addition, 15 (12.8%) of patients stated that they developed complications post-op. Among those who developed complications, 11 (9.4%) had wound infection.

4.2.2 Perception of patients about quality of health services

Table (4.26a): Perception of patients about meeting expectations (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	My experience was good with regard to the health care and service provided to me in this hospital	n	0	3	30	87	55	4.11	0.739	82.2	5
		%	0	1.7	17.1	49.7	31.4				
2	I received the health services I was expecting	n	0	5	28	83	59	4.12	0.775	82.4	4
		%	0	2.9	16.0	47.4	33.7				
3	My need for pain-relieving medication was taken into account	n	0	4	20	79	72	4.25	0.746	85.0	2
		%	0	2.3	11.4	45.1	41.1				
4	I received different means to relieve the pain	n	0	9	17	74	75	4.23	0.826	84.6	3
		%	0	5.1	9.7	42.3	42.9				
5	The standards of service I recognized through the hospital staff were excellent	n	0	2	13	74	86	4.39	0.677	87.8	1
		%	0	1.1	7.4	42.3	49.1				
Average								4.22	0.585	84.4	

Table (4.26a) showed that the highest score was in the item “The standards of service I recognized through the hospital staff were excellent” with mean score 4.39 and weighted percent 87.8%, followed by “My need for pain-relieving medication was taken into account” with mean score 4.25 and weighted percent 85%, while the lowest score was in “My experience was good with regard to the health care and service provided to me in this hospital” with mean score 4.11 and weighted percent 82.2%, followed by “I received the health services I was expecting” with mean score 4.12 and weighted percent 82.4%. The average mean score was 4.22 and weighted percent 84.4%. This result is congruent with study conducted by (AbuSada, 2013) that found the meeting expectation domain reported a mean of 4.0467 (80.90%) of perception level. The researcher sees that the result indicates the patients have a positive perception about meeting the expectation domain in the SHMC. As stated by the general director, *“the patient certainly receives the services that he expects in Al-Shifa Medical Complex, but sometimes the lack of supplies, medicines, and some services beyond our control may affect the patient’s opinion and what he expects of services.”*

We always strive to find solutions to all problems and find everything that meets and fills the patient's needs within Al-Shifa Medical Complex."

In addition, the general director said, *"The patient certainly receives the services that he expects in Al-Shifa Medical Complex, but sometimes the lack of supplies, medicines, and some services beyond our control may affect the patient's opinion and what he expects of services. We always strive to find solutions to all problems and find everything that meets and fills the patient's needs within Al-Shifa Medical Complex."*

Table (4.26b): Perception of patients about information and communication (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	I was involved in making decisions about my health condition	n	1	4	25	81	64	4.16	0.793	83.2	5
		%	0.6	2.3	14.3	46.3	36.6				
2	I received adequate information about my health condition	n	0	2	16	81	76	4.32	0.687	86.4	3
		%	0	1.1	9.1	46.3	43.4				
3	I was provided with a full explanation of the operations and care provided me by health service providers	n	4	4	26	83	58	4.07	0.881	81.4	6
		%	2.3	2.3	14.9	47.4	33.1				
4	The hospital staff used to introduce themselves to me	n	0	6	13	54	102	4.44	0.777	88.8	1
		%	0	3.4	7.4	30.9	58.3				
5	I received satisfactory and adequate answers to my questions from health care provider	n	0	3	21	80	71	4.25	0.731	85.0	4
		%	0	1.7	12.0	45.7	40.6				
6	I feel that I'm close to the health providers	n	0	6	13	63	93	4.39	0.772	87.8	2
		%	0	3.4	7.4	36.0	53.1				
Average								4.27	0.582	85.4	

Table (4.26b) showed that the highest score was in the item “The hospital staff used to introduce themselves to me” with mean score 4.44 and weighted percent 88.8%, followed by “I feel that I’m close to the health providers” with mean score 4.39 and weighted percent 87.8%, while the lowest score was in “I was provided with a full explanation of the operations and care provided me by health service providers” with mean score 4.07 and weighted percent 81.4%, followed by “I was involved in making decisions about my health

condition” with mean score 4.16 and weighted percent 83.2%. The average mean score was 4.27 and weighted percent 85.4%. This result is congruent with study conducted by (AbuSada, 2013) that found the information and communication domain reported a mean 3.9767 (79.50%) of the perception level. And the result is inconsistent with a study conducted by (Abu Hasera, 2016) that found the information and communication domain reported a mean of 60.77% of the perception level. The researcher sees that the result indicates the patients have a positive perception of the information and communication domain in the SHMC. *As the medical director stated, “There is a clear problem regarding the item of information and communication with patients, which is caused by the medical staff who often do not provide the patient with all the health information he needs about his health condition. Which creates problems for us with patients and their families. I cannot say that we cover this subject sufficiently, required, and appropriately.*

Table (4.26c): Perception of patients about hospital culture (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	The hospital staff treat patients equally	n	0	5	13	60	97	4.42	0.753	88.4	4
		%	0	2.9	7.4	34.3	55.4				
2	The hospital staff respond to my requests quickly	n	0	5	16	50	104	4.45	0.778	89.0	3
		%	0	2.9	9.1	28.6	59.4				
3	The hospital staff work together as a team	n	0	2	10	51	112	4.56	0.657	91.2	1
		%	0	1.1	5.7	29.1	64.0				
4	My health service is properly provided	n	0	1	12	52	110	4.55	0.649	91.0	2
		%	0	0.6	6.9	29.7	62.9				
5	The medical equipment needed to provide health services are available	n	5	23	77	53	17	3.31	0.920	66.2	6
		%	2.9	13.1	44.0	30.3	9.7				
6	The medical examinations necessary to provide the health services are available	n	0	8	36	117	14	3.78	0.651	75.6	5
		%	0	4.6	20.6	66.9	8.0				
Average								4.17	0.474	83.4	

Table (4.26c) showed that the highest score was in the item “The hospital staff work together as a team” with mean score 4.56 and weighted percent 91.2%, followed by “My health service is properly provided” with mean score 4.55 and weighted percent 91%, while the lowest score was in “The medical equipment needed to provide health services are available” with mean score 3.31 and weighted percent 66.2%, followed by “The medical examinations necessary to provide the health services are available” with mean score 3.78 and weighted

percent 75.6%. The average mean score was 4.17 and weighted percent 83.4%. This result is inconsistent with a study conducted by (AbuSada, 2013) that found the patients' perception of the hospital culture domain was 3.8607(mean) with 77.20 % of perception level with a moderate perception. Moreover the result inconsistent to a study conducted by (Abu Hasera, 2016) that found the patients' perception of the hospital culture domain was 49.10% of the perception level.

The researcher sees that the result indicates the patients have a positive perception of the information and communication domain in the SHMC. *As the director of nursing stated and confirmed in this regard "we inside Al-Shifa Medical Complex, fill out a questionnaire with patients to take their views on the extent of their satisfaction with the health service provided to them, and that is every period and periodically, and the results were high and satisfactory about the services they receive within the departments of Al-Shifa Medical Complex."*

Table (4.26d): Perception of patients about respect and privacy (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	I feel interest and follow up from the staff about my health	n	0	4	7	69	95	4.46	0.684	89.2	6
		%	0	2.3	4.0	39.4	54.3				
2	I feel that the hospital staff care about what I say	n	0	5	13	52	105	4.47	0.756	89.4	4
		%	0	2.9	7.4	29.7	60.0				
3	The hospital staff treats me in a friendly manner despite their busyness	n	1	3	13	58	100	4.45	0.755	89.0	7
		%	0.6	1.7	7.4	33.1	57.1				
4	I felt that the hospital staff cared about me as human being	n	0	4	9	61	101	4.48	0.702	89.6	3
		%	0	2.3	5.1	34.9	57.7				
5	I have high confidence in the hospital staff	n	1	1	10	61	102	4.50	0.685	90.0	2
		%	0.6	0.6	5.7	34.9	58.3				
6	The level of appreciation and respect shown by the hospital staff was excellent	n	0	3	12	60	100	4.47	0.701	89.4	5
		%	0	1.7	6.9	34.3	57.1				
7	The hospital staff is keen on patients' privacy when conducting examinations	n	0	4	11	50	110	4.52	0.718	90.4	1
		%	0	0.2.3	6.3	28.6	62.9				
Average								4.47	0.519	89.4	

Table (4.26d) showed that the highest score was in the item “The hospital staff is keen on patients’ privacy when conducting examinations” with mean score 4.52 and weighted percent 90.4%, followed by “I have high confidence in the hospital staff” with mean score 4.50 and weighted percent 90%, while the lowest score was in “The hospital staff treats me in a friendly manner despite their busyness” with mean score 4.45 and weighted percent 89%, followed by “I feel interest and follow up from the staff about my health” with mean score 4.46 and weighted percent 89.2%. The average mean score was 4.47 and weighted percent 89.4%.

This result is consistent with a study conducted by (AbuSada, 2013) that found the perception of patients about respect and privacy domain was 87.51% with a high perception level. In addition, this result is inconsistent with a study conducted by (Abu Hasera, 2016) that found the perception of patients about respect and privacy domain was 65.30% with moderate perception.

The researcher sees that the result indicates the patients have a high positive perception of respect and privacy domain in the SHMC. *The general director also stated that, to some extent, "there is privacy for the patient when dealing with him, when examining him, and taking any medical procedure with him, the patient is treated with the required respect, and there is confidentiality about his health information. Also, patients' files and their information are not shared with anyone."*

Table (4.26e): Perception of patients about approach of care (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	The hospital staff fulfill my requests in real time	n	1	6	13	62	93	4.37	0.812	87.4	5
		%	0.6	3.4	7.4	35.4	53.1				
2	I feel satisfied with the capabilities of the staff treating me	n	0	2	11	58	104	4.51	0.668	90.2	4
		%	0	1.1	6.3	33.1	59.4				
3	The hospital staff come to me constantly and regularly	n	0	2	9	56	108	4.54	0.650	90.8	3
		%	0	1.1	5.1	32.0	61.7				
4	I bought drugs from my own account because they weren't available in the hospital	n	1	11	9	21	133	4.57	0.894	91.4	1
		%	0.6	6.3	5.1	12.0	76.0				
5	The medications are given to me at set time	n	0	2	11	51	111	4.55	0.667	91.0	2
		%	0	1.1	6.3	29.1	63.4				
6	The process of admission to the hospital was easy and without obstacles	n	18	54	46	31	26	2.96	1.224	59.2	7
		%	10.3	30.9	26.3	17.7	14.9				
7	The discharge process was easy and without obstacles	n	16	53	39	38	29	3.06	1.246	61.2	6
		%	9.1	30.3	22.3	21.7	16.6				
Average								4.08	0.475	81.6	

Table (4.26e) showed that the highest score was in the item “I bought drugs from my own account because they weren't available in the hospital” with mean score 4.57 and weighted percent 91.4%, followed by “The medications are given to me at set time” with mean score 4.55 and weighted percent 91%, while the lowest score was in “The process of admission to the hospital was easy and without obstacles” with mean score 2.96 and weighted percent 59.2%, followed by “The discharge process was easy and without obstacles” with mean score 3.06 and weighted percent 61.2%. The average mean score was 4.08 and weighted percent 81.6%. This result is consistent with a study conducted by (AbuSada, 2013) that found the perception of patients about the approach of care domain was a mean of 4.1828 (82.2%) with a high level of perception. And the result is inconsistent with a study conducted by (Abu Hasera, 2016) that found the perception of patients about the approach of care domain was a mean of 71.63% with a moderate level of perception.

The researcher sees that the result indicates the patients have a positive perception of approach of care domain in the SHMC but in the item "I bought drugs from my own account because they weren't available in the hospital," there was a general agreement from all patients that they had purchased medicines that were prescribed for them from their own accounts and that they had to be available to them inside the complex, which reflects the existence of a shortage of many medicines inside Al-Shifa Medical Complex, due to the inability of the Ministry of Health to provide what is needed and the blockade imposed on the Gaza Strip.

The medical director also stated and said regarding the health care approach within the Shifa Medical Complex that " there is everything necessary to provide the service, but sometimes some obstacles appear, such as buying medicines from outside the hospital and at the expense of the patient due to the lack of them within the Ministry of Health and the Al Shifa Medical Complex, as well as on the subject of the admission and discharge mechanism for patients sometimes because the increasing number of reluctant cases and the pressure of work on emergency departments and outpatient clinics, which are the places through which patients enter the departments, this leads to an obstruction in the entry mechanism used."

In addition, the nursing director said in this regard that *"the issue of purchasing medicines from abroad is very rare, and we use alternatives from within the complex, and the mechanisms of entry and exit differ from one department to the next, such as surgical patients who take the service and leave without difficulty, as opposed to internal medicine patients, who require services more than others."*

Table (4.26f): Perception of patients about hotel services (n= 175)

No.	Item		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	Mean	SD	%	Rank
1	The cleanliness of the toilets is good	n	2	4	18	54	97	4.37	0.847	87.4	3
		%	1.1	2.3	10.3	30.9	55.4				
2	There is special concern about patient’s safety	n	1	2	23	54	95	4.37	0.798	87.4	4
		%	0.6	1.1	13.1	30.9	54.3				
3	Bed linen are always clean	n	0	1	11	59	104	4.52	0.642	90.4	1
		%	0	0.6	6.3	33.7	59.4				
4	Bed linen are always available	n	1	2	16	55	101	4.45	0.755	89.0	2
		%	0.6	1.1	9.1	31.4	57.7				
Average								4.42	0.675	88.4	

Table (4.26f) showed that the highest score was in the item “Bed linen are always clean” with mean score 4.52 and weighted percent 90.4%, followed by “Bed linen are always available” with mean score 4.45 and weighted percent 89%, while the lowest score was in “There is special concern about patient’s safety” with mean score 4.37 and weighted percent 87.4%, followed by “The cleanliness of the toilets is good” with mean score 4.37 and weighted percent 87.4%. The average mean score was 4.42 and weighted percent 88.4%. This result is inconsistent with a study conducted by (AbuSada, 2013) that found the perception of patients about hotel services was a mean of 3.4689 (68.38%) with a moderate level of perception. The researcher sees that the result indicates the patients have a high positive perception of the hotel services domain in the SHMC.

The general director of the complex also stated, regarding the hotel services, "that they are of high quality and are provided in an appropriate and required manner. The level of cleanliness inside the complex is high due to the presence of a cleaning company that works around the clock. Also, bed covers are available and the patient is provided with everything necessary. As the meals provided to patients, it has been stopped by the Ministry of Health, but without that, the hotel service is provided to the fullest within the Al-Shifa Medical Complex."

Table (4.27): Overall perception of patients about quality of health services (n= 175)

Item	Mean	SD	%	Rank
Meeting expectations	4.22	0.585	84.4	4
Information and communication	4.27	0.582	85.4	3
Hospital culture	4.17	0.474	83.4	5
Respect and privacy	4.47	0.519	89.4	1
Approach of care	4.08	0.475	81.6	6
Hotel services	4.42	0.675	88.4	2
Overall satisfaction	4.26	0.417	85.2	

Table (4.27) showed that the highest score was in the respect and privacy domain (m= 4.47, 89.4%), followed by hotel services (m= 4.42, 88.4%), information and communication (m= 4.27, 85.4%), meeting expectation (m= 4.22, 84.4%), hospital culture (m= 4.17, 83.4%), and the lowest score was in approach of care (m= 4.08, 81.6). The overall mean score was 4.26 and the weighted percentage was 85.2%, which indicated high level of patients' satisfaction with quality of health services.

This result is consistent with a study conducted by (F. Y. M. Al-Jabri et al., 2021) the study found that patients' perceptions of quality care were generally positive. In general, patients were more satisfied when healthcare providers paid attention to their individual needs, treated them with kindness, and when felt they had a say in their care. The researcher attributed the reason for these domains obtaining a high degree of approval to a realization patients due to the quality of the services provided to them, and their apparent satisfaction with these services is because some of the workers are qualified and fully aware of what to do in most of the sick cases they face in the hospital, and they strive to provide the health service at a decent level despite the lack of possibilities, and the comparisons made by the recipient of the service between what you expected to find according to what His reputation about the hospital and what exists on the ground positively influence its approval if you get what you want with reasonable effort; Where workers consider the patient's privacy as one of their priorities and are aware of it at a low level, and they want to improve it continuously even though it obtains a large degree of approval from the recipients of the service.

4.2.3 Differences in perception about quality of health services related to sociodemographic characteristics of patients

Table (4.28): Differences in perception about quality of health services related to gender

Domain	Gender	n	Mean	SD	t	P value
Meeting expectations	Male	86	4.209	0.577	-0.250	0.803
	Female	89	4.231	0.596		
Information and communication	Male	86	4.302	0.571	0.688	0.492
	Female	89	4.241	0.594		
Hospital culture	Male	86	4.127	0.494	-1.380	0.170
	Female	89	4.226	0.451		
Respect and privacy	Male	86	4.516	0.471	0.998	0.320
	Female	89	4.438	0.561		
Approach of care	Male	86	4.099	0.529	0.537	0.592
	Female	89	4.061	0.418		
Hotel services	Male	86	4.500	0.650	1.405	0.162
	Female	89	4.356	0.695		
Total	Male	86	4.284	0.419	0.476	0.635
	Female	89	4.253	0.416		

Independent sample (t) test

Table (4.28) showed that there were statistically no significant differences in quality of health services in all the domains and the total score related to gender of patients ($P= 0.635$).

The result of the study showed that there is no difference between male and female patients in terms of perceived the quality of the healthcare services provided at Al-Shifa Medical Complex during their stay. Also, it indicates that patients of both sexes are satisfied with healthcare services provided at Al-Shifa Medical Complex. These results are expected because the health services provided to all people in the same way.

Table (4.29): Differences in perception about quality of health services related to age

Age		n	Mean	SD	F	P value
Meeting expectations	20 years and less	16	4.350	0.346	0.430	0.787
	21-30 years	29	4.241	0.488		
	31-40 years	71	4.183	0.625		
	41-50 years	30	4.280	0.609		
	51 years and more	29	4.158	0.666		
	Total	175	4.220	0.585		
Information and communication	20 years and less	16	4.447	0.433	1.205	0.311
	21-30 years	29	4.149	0.593		
	31-40 years	71	4.260	0.592		
	41-50 years	30	4.400	0.559		
	51 years and more	29	4.189	0.631		
	Total	175	4.271	0.582		
Hospital culture	20 years and less	16	4.302	0.340	0.901	0.465
	21-30 years	29	4.051	0.429		
	31-40 years	71	4.171	0.577		
	41-50 years	30	4.233	0.329		
	51 years and more	29	4.195	0.420		
	Total	175	4.178	0.474		
Respect and privacy	20 years and less	16	4.696	0.372	1.611	0.174
	21-30 years	29	4.320	0.666		
	31-40 years	71	4.450	0.519		
	41-50 years	30	4.552	0.400		
	51 years and more	29	4.497	0.507		
	Total	175	4.476	0.519		
Approach of care	20 years and less	16	4.178	0.273	0.560	0.692
	21-30 years	29	4.073	0.589		
	31-40 years	71	4.024	0.524		
	41-50 years	30	4.104	0.412		
	51 years and more	29	4.142	0.366		
	Total	175	4.080	0.475		
Hotel services	20 years and less	16	4.765	0.422	1.266	0.285
	21-30 years	29	4.405	0.819		
	31-40 years	71	4.348	0.648		
	41-50 years	30	4.433	0.675		
	51 years and more	29	4.448	0.682		
	Total	175	4.427	0.675		
Total	20 years and less	16	4.441	0.261	1.194	0.315
	21-30 years	29	4.194	0.486		
	31-40 years	71	4.235	0.449		
	41-50 years	30	4.329	0.292		
	51 years and more	29	4.268	0.432		
	Total	175	4.268	0.417		

Table (4.29) showed that there were statistically no significant differences in quality of health services in all the domains and the total score related to age of patients ($P= 0.315$).

According to the result of the study, all age groups of inpatients received similar healthcare services at the Al-Shifa Medical Complex. This demonstrates that Al Shifa Medical Complex provides healthcare services in accordance with professional standards regardless of the patient's age, which increases credibility and trusts more than it increases patient satisfaction.

Table (4.30): Differences in patients' perception about quality of health services related to marital status

Marital status		n	Mean	SD	F	P value
Meeting expectations	Single	40	4.220	0.593	0.478	0.698
	Married	109	4.194	0.579		
	Divorced	12	4.400	0.620		
	Widow	14	4.271	0.615		
	Total	175	4.220	0.585		
Information and communication	Single	40	4.375	0.605	1.545	0.205
	Married	109	4.209	0.568		
	Divorced	12	4.513	0.529		
	Widow	14	4.250	0.636		
	Total	175	4.271	0.582		
Hospital culture	Single	40	4.216	0.457	1.207	0.309
	Married	109	4.143	0.476		
	Divorced	12	4.402	0.365		
	Widow	14	4.142	0.565		
	Total	175	4.178	0.474		
Respect and privacy	Single	40	4.496	0.576	1.956	0.123
	Married	109	4.432	0.526		
	Divorced	12	4.809	0.300		
	Widow	14	4.479	0.339		
	Total	175	4.476	0.519		
Approach of care	Single	40	4.067	0.500	1.823	0.145
	Married	109	4.076	0.494		
	Divorced	12	4.345	0.319		
	Widow	14	3.918	0.242		
	Total	175	4.080	0.475		
Hotel services	Single	40	4.581	0.638	1.700	0.169
	Married	109	4.353	0.703		
	Divorced	12	4.333	0.651		
	Widow	14	4.642	0.497		
	Total	175	4.427	0.675		
Total	Single	40	4.312	0.476	1.524	0.210
	Married	109	4.230	0.404		
	Divorced	12	4.483	0.330		
	Widow	14	4.259	0.371		
	Total	175	4.268	0.417		

Table (4.30) showed that there were statistically no significant differences in quality of health services in all the domains and the total score related to marital status of patients ($P=0.315$). The researcher claims that regardless of the patient's marital status, i.e., whether the patient is married, single, widowed, or divorced they are given the same healthcare services at AlShifa Medical Complex without discrimination. We can conclude that Al Shifa Medical Complex does not use a patient's social condition as a justification for changing in the healthcare services provided and gives all patients the healthcare service equally.

Table (4.31a): Differences in patients' perception about quality of health services related to place of residency

Governorate		n	Mean	SD	F	P value
Meeting expectations	Gaza	62	4.245	0.588	2.421	0.050 *
	North	56	4.050	0.654		
	Middle	39	4.400	0.496		
	Khanyounis	15	4.226	0.413		
	Rafah	3	4.533	0.115		
	Total	175	4.220	0.585		
Information and communication	Gaza	62	4.215	0.553	2.803	0.027 *
	North	56	4.136	0.682		
	Middle	39	4.444	0.428		
	Khanyounis	15	4.455	0.536		
	Rafah	3	4.777	0.254		
	Total	175	4.271	0.582		
Hospital culture	Gaza	62	4.185	0.420	3.947	0.004 *
	North	56	4.008	0.601		
	Middle	39	4.290	0.330		
	Khanyounis	15	4.455	0.231		
	Rafah	3	4.333	0.333		
	Total	175	4.178	0.474		
Respect and privacy	Gaza	62	4.435	0.490	2.326	0.058
	North	56	4.357	0.630		
	Middle	39	4.626	0.387		
	Khanyounis	15	4.657	0.357		
	Rafah	3	4.714	0.494		
	Total	175	4.476	0.519		
Approach of care	Gaza	62	4.103	0.451	3.581	0.008 *
	North	56	3.928	0.516		
	Middle	39	4.131	0.440		
	Khanyounis	15	4.304	0.332		
	Rafah	3	4.619	0.329		
	Total	175	4.080	0.475		
Hotel services	Gaza	62	4.330	0.689	1.343	0.256
	North	56	4.442	0.750		
	Middle	39	4.423	0.601		
	Khanyounis	15	4.666	0.487		
	Rafah	3	5.000	0.000		
	Total	175	4.427	0.675		
Total	Gaza	62	4.249	0.375	3.700	0.006 *
	North	56	4.139	0.521		
	Middle	39	4.383	0.305		
	Khanyounis	15	4.457	0.236		
	Rafah	3	4.647	0.164		
	Total	175	4.268	0.417		

*Significant at 0.05

Table (4.31a) showed that there were statistically significant differences in perception about quality of health services related to place of residency ($P= 0.006$). To find the direction of these differences, the researcher performed LSD test as shown in table (4.31b).

Table (4.31b): Post hoc LSD test for place of residency

Domain	Governorate		Mean Difference	P value
Meeting expectations	North	Gaza	-0.195	0.068
		Middle	-0.350	0.004 *
		Khanyounis	-0.176	0.293
		Rafah	-0.483	0.159
Information and communication	North	Gaza	-0.078	0.459
		Middle	-0.307	0.011 *
		Khanyounis	-0.318	0.057
		Rafah	-0.640	0.060
Hospital culture	North	Gaza	-0.176	0.038 *
		Middle	-0.281	0.004 *
		Khanyounis	-0.446	0.001 *
		Rafah	-0.324	0.235
Approach of care	North	Gaza	-0.175	0.041 *
		Middle	-0.203	0.036 *
		Khanyounis	-0.376	0.006 *
		Rafah	-0.690	0.013 *
Total	North	Gaza	-0.109	0.144
		Middle	-0.243	0.004 *
		Khanyounis	-0.317	0.008 *
		Rafah	-0.507	0.036 *

*Significant at 0.05

Table (4.31b) showed that patients from the North governorate expressed significant lower perception about quality of health services compared to patients from the other governorates. The researcher believes that the reason for giving the recipients of the service from the residents of the North Governorate a small percentage of perception and approval is due to the distance between the Al Shifa Medical Complex and their original place of residence and the presence of the hospital in a place in the middle of the sector, which is difficult to access, and most of the cases are service recipients who reach the complex for necessity, due to the lack of certain specialties in hospitals close to them, which leads them to resort to the Al-Shifa Medical Complex and have to be treated in its different departments. Just as patients from the northern governorates have a special culture that differs from other cultures for patients in the rest of the governorates of Gaza, it may be an obstacle for patients to deal with the situation inside the Al Shifa Medical complex, which gives them the impression of discomfort in the complex.

Table (4.32): Differences in patients' perception about quality of health services related to type of citizenship

Domain	Citizenship	n	Mean	SD	t	P value
Meeting expectations	Refugee	140	4.255	0.569	1.595	0.113
	Citizen	35	4.080	0.634		
Information and communication	Refugee	140	4.307	0.579	1.629	0.105
	Citizen	35	4.128	0.581		
Hospital culture	Refugee	140	4.172	0.496	-0.305	0.761
	Citizen	35	4.200	0.378		
Respect and privacy	Refugee	140	4.489	0.512	0.664	0.508
	Citizen	35	4.424	0.551		
Approach of care	Refugee	140	4.074	0.473	-0.306	0.760
	Citizen	35	4.102	0.488		
Hotel services	Refugee	140	4.494	0.622	2.689	0.008 *
	Citizen	35	4.157	0.811		
Total	Refugee	140	4.288	0.417	1.233	0.219
	Citizen	35	4.191	0.415		

Table (4.32) showed that there were statistically no significant differences in all the domains of quality of health services except hotel services domain, which indicated that refugee patients expressed significant favored perception about hotel services compared to Citizen patients. The researcher believes that giving the refugee patients a higher impression and perception than the patients of the citizen group indicate the extent of the conviction and satisfaction of the refugee patients with the hotel services provided in the SHMC and their conviction that hotel services have evolved from the previous.

The majority of Palestinian refugees are from low-income areas and have workers' health insurance, social security insurance, and other forms of insurance that do not allow them to go to private hospitals that have superior and more modern hotel services than government hospitals, as do the majority of citizen patients, who gave a less favorable impression of hotel services within the SHMC.

Table (4.33): Differences in patients' perception about quality of health services related to level of education

Level of education		n	Mean	SD	F	P value
Meeting expectations	Primary school	19	4.389	0.385	1.029	0.381
	Prep school	32	4.156	0.627		
	Secondary school	69	4.162	0.563		
	University	55	4.272	0.639		
	Total	175	4.220	0.585		
Information and communication	Primary school	19	4.438	0.503	0.942	0.422
	Prep school	32	4.234	0.631		
	Secondary school	69	4.207	0.538		
	University	55	4.315	0.629		
	Total	175	4.271	0.582		
Hospital culture	Primary school	19	4.228	0.393	0.972	0.407
	Prep school	32	4.291	0.518		
	Secondary school	69	4.128	0.469		
	University	55	4.157	0.478		
	Total	175	4.178	0.474		
Respect and privacy	Primary school	19	4.654	0.404	0.891	0.447
	Prep school	32	4.491	0.575		
	Secondary school	69	4.445	0.481		
	University	55	4.446	0.565		
	Total	175	4.476	0.519		
Approach of care	Primary school	19	4.203	0.404	0.654	0.581
	Prep school	32	4.026	0.557		
	Secondary school	69	4.095	0.462		
	University	55	4.049	0.465		
	Total	175	4.080	0.475		
Hotel services	Primary school	19	4.736	0.452	2.091	0.103
	Prep school	32	4.460	0.663		
	Secondary school	69	4.431	0.575		
	University	55	4.295	0.826		
	Total	175	4.427	0.675		
Total	Primary school	19	4.425	0.317	1.049	0.374
	Prep school	32	4.268	0.493		
	Secondary school	69	4.238	0.375		
	University	55	4.253	0.448		
	Total	175	4.268	0.417		

*Significant at 0.05

Table (4.33) showed that there were statistically no significant differences in perception about quality of health services related to patients' level of education in all the domains and the total score ($P= 0.374$). According to the results, healthcare services at Al Shifa Medical Complex are provided equally for all patients as required regardless of the patient's educational level. It's indicated that educated and uneducated patients received the same healthcare services. Also, this increases the patient's confidence and satisfaction.

Table (4.34a): Differences in patients' perception about quality of health services related to work

Work		n	Mean	SD	F	P value
Meeting expectations	Not working	104	4.167	0.582	1.089	0.339
	Employee	56	4.307	0.610		
	Free work	15	4.266	0.499		
	Total	175	4.220	0.585		
Information and communication	Not working	104	4.209	0.593	1.543	0.217
	Employee	56	4.378	0.560		
	Free work	15	4.300	0.567		
	Total	175	4.271	0.582		
Hospital culture	Not working	104	4.189	0.456	0.220	0.802
	Employee	56	4.145	0.461		
	Free work	15	4.222	0.647		
	Total	175	4.178	0.474		
Respect and privacy	Not working	104	4.410	0.558	3.209	0.043 *
	Employee	56	4.619	0.419		
	Free work	15	4.400	0.498		
	Total	175	4.476	0.519		
Approach of care	Not working	104	4.041	0.466	0.904	0.407
	Employee	56	4.127	0.494		
	Free work	15	4.171	0.465		
	Total	175	4.080	0.475		
Hotel services	Not working	104	4.355	0.660	1.656	0.194
	Employee	56	4.504	0.711		
	Free work	15	4.633	0.611		
	Total	175	4.427	0.675		
Total	Not working	104	4.223	0.428	1.549	0.215
	Employee	56	4.340	0.387		
	Free work	15	4.314	0.434		
	Total	175	4.268	0.417		

Table (4.34b): Post hoc LSD test for work

Domain	Governorate		Mean Difference	P value
Respect and privacy	Not working	Employee	-0.209	0.015 *
		Free work	0.010	0.940

Table (4.34a) showed that there were statistically no significant differences in perception about quality of health services related to patients' work in all the domains and the total score (P= 0.215). The results also showed that there were statistically significant differences in respect and privacy. To find the direction of these differences, the researcher performed Post

hoc LSD test as presented in table (4.34b), which showed that patients who do not work expressed significant lower perception about respect and privacy compared to patients who are employed ($P= 0.015$). The researcher attributed that patients who do not work expressed significantly lower perceptions of respect and privacy compared to patients who are employed because of the satisfaction of the target groups to a small degree that they find through dealing with service providers in the hospital, and this means that the health care provider does not enjoy a good reputation in terms of equal treatment, and also these patients feel annoyed when they are asked to buy medicines from outside the hospital and are also asked to conducting tests that require a sum of money, such as making a CT image, MRI or cardiac catheterization, and they do not have the required money, which puts them in embarrassment.

Table (4.35): Differences in patients' perception about quality of health services related to number of admissions

Domain	Admission	n	Mean	SD	t	P value
Meeting expectations	Many times	42	4.066	0.611	-1.970	0.050 *
	First time	133	4.269	0.571		
Information and communication	Many times	42	4.115	0.586	-2.012	0.046 *
	First time	133	4.320	0.575		
Hospital culture	Many times	42	4.170	0.489	-0.117	0.907
	First time	133	4.180	0.471		
Respect and privacy	Many times	42	4.374	0.540	-1.473	0.143
	First time	133	4.509	0.510		
Approach of care	Many times	42	4.023	0.474	-0.878	0.381
	First time	133	4.097	0.475		
Hotel services	Many times	42	4.309	0.713	-1.296	0.197
	First time	133	4.464	0.662		
Total	Many times	42	4.173	0.412	-1.706	0.090
	First time	133	4.298	0.416		

Table (4.35) showed that patients who have been admitted to the hospital many times expressed significant lowered perception about meeting expectations ($P= 0.050$) and information and communication ($P= 0.046$) compared to patients who have been admitted for the first time. The results also showed that there were statistically no significant differences in perception about hospital culture ($P= 0.907$), respect and privacy ($P= 0.143$), approach of care ($P= 0.381$), hotel services ($P= 0.197$), and total score ($P= 0.090$).

The researcher attributed this low result to patients who have been admitted to the hospital many times expressing significantly lower perceptions about meeting expectations and information and communication. Since the vast number of service recipients who frequent

and the large number of overnight stays who have previously visited the complex and the hospital departments, they have prior knowledge of the services provided and do not have a new expectation for the services that they will receive on successive visits. As for the information they received, only a small percentage was taken. From the perception they have, as a result, the patients have sufficient information according to their cases, and they were explained in advance about their health status when they were admitted to the previous times in the hospital, and what compels doctors and nurses to take the necessary measures for them with high efficiency, without providing a full explanation and providing complete information about the case, until there is no sufficient time for the doctors to give a full explanation about the health status of the recurrent patient who has been previously admitted.

Table (4.36): Differences in patients' perception about quality of health services related to method of admission

Method of admission		n	Mean	SD	F	P value
Meeting expectations	Urgent	96	4.181	0.614	2.676	0.022 *
	OPD	58	4.186	0.576		
	From private clinic	21	4.495	0.393		
	Total	175	4.220	0.585		
Information and communication	Urgent	96	4.255	0.565	0.702	0.497
	OPD	58	4.247	0.631		
	From private clinic	21	4.412	0.526		
	Total	175	4.271	0.582		
Hospital culture	Urgent	96	4.178	0.463	1.403	0.249
	OPD	58	4.123	0.530		
	From private clinic	21	4.325	0.322		
	Total	175	4.178	0.474		
Respect and privacy	Urgent	96	4.485	0.533	0.345	0.709
	OPD	58	4.438	0.508		
	From private clinic	21	4.544	0.498		
	Total	175	4.476	0.519		
Approach of care	Urgent	96	4.089	0.492	0.040	0.961
	OPD	58	4.069	0.450		
	From private clinic	21	4.068	0.483		
	Total	175	4.080	0.475		
Hotel services	Urgent	96	4.427	0.719	0.066	0.936
	OPD	58	4.444	0.660		
	From private clinic	21	4.381	0.516		
	Total	175	4.427	0.675		
Total	Urgent	96	4.264	0.424	0.658	0.519
	OPD	58	4.242	0.424		
	From private clinic	21	4.363	0.368		
	Total	175	4.268	0.417		

Table (4.36b): Post hoc LSD test for method of admission

Domain	Method of admission		Mean Difference	P value
Meeting expectations	From private clinic	Urgent	0.313	0.026 *
		OPD	0.309	0.038 *

Table (4.36a) showed that there were statistically no significant differences in the domains and total score of quality health services, while there were statistically significant differences in meeting expectations. As demonstrated in table (4.36b), Post hoc LSD test showed that patients who have been referred from private clinic expressed statistically significant higher perception about meeting expectations compared to patients who have been admitted urgently from ER ($P= 0.026$), and patients who have been admitted from the out-patient department ($P= 0.038$).

According to the researcher, patients who were referred from a private clinic before being admitted to the hospital may have negative impressions and unmet expectations about the quality of healthcare services provided. However, they may have been pleasantly surprised by the level of care they received, which is a good sign for the complex's level of healthcare services.

Table (4.37): Differences in patients' perception about quality of health services related to department

Domain	Department	n	Mean	SD	t	P value
Meeting expectations	Medical	58	4.289	0.560	1.099	0.273
	Surgical	117	4.186	0.596		
Information and communication	Medical	58	4.339	0.545	1.082	0.281
	Surgical	117	4.237	0.599		
Hospital culture	Medical	58	4.175	0.469	-0.055	0.956
	Surgical	117	4.179	0.478		
Respect and privacy	Medical	58	4.586	0.449	3.110	0.037 *
	Surgical	117	4.422	0.544		
Approach of care	Medical	58	4.115	0.448	0.700	0.485
	Surgical	117	4.062	0.488		
Hotel services	Medical	58	4.629	0.515	3.176	0.002 *
	Surgical	117	4.326	0.724		
Total	Medical	58	4.341	0.374	1.724	0.087
	Surgical	117	4.232	0.434		

Table (4.37) showed that patients from medical departments exhibited statistically significant higher perception about respect and privacy ($P=0.037$), and significant higher perception about hotel services ($P= 0.002$) compared to patients from surgical departments, while there were no significant differences in the other domains and the total score.

The researcher attributes patients from medical departments exhibited a statistically significant higher perception of respect and privacy and a significantly higher perception of hotel services compared to patients from surgical departments. Indeed, the patients in the medical departments stay for more extended periods than patients in the surgical departments who perform operations and surgical procedures and then leave the hospital faster than patients in the medical departments, so the view of these patients in the medical departments and their perception of the quality of services in terms of respect and privacy, as well as hotel services, this high perception comes only after the patients stay overnight for long periods of stay, the patient can evaluate the services provided in all respects, and this gives credibility to the information after trying the benefits for a more extended period.

Patients' satisfaction reflects a high degree in terms of justice, respect, and privacy that they find through dealing with service providers, and this means that employees have a good reputation in terms of equal treatment, and services provided in the hospital despite the scarcity of resources, and the employees not receiving their salaries, and bearing huge workloads; due to the shortage of workers from various specialties. About hotel services, the key managers in the complex stated, after meeting with the interviewees, that there is a cleaning company that works around the clock in cleaning the buildings and sections of the complex. Our study found that the level of hotel services was high.

Table (4.38a): Differences in patients' perception about quality of health services related to length of stay in the hospital

Length of stay in the hospital		n	Mean	SD	F	P value
Meeting expectations	1-3 days	19	4.147	0.376	1.807	0.148
	4-6 days	100	4.166	0.639		
	7-9 days	35	4.422	0.575		
	10 days and more	21	4.209	0.421		
	Total	175	4.220	0.585		
Information and communication	1-3 days	19	4.175	0.504	2.683	0.048 *
	4-6 days	100	4.201	0.623		
	7-9 days	35	4.509	0.533		
	10 days and more	21	4.293	0.431		
	Total	175	4.271	0.582		
Hospital culture	1-3 days	19	4.122	0.480	0.209	0.890
	4-6 days	100	4.168	0.508		
	7-9 days	35	4.219	0.389		
	10 days and more	21	4.206	0.450		
	Total	175	4.178	0.474		
Respect and privacy	1-3 days	19	4.375	0.563	2.749	0.044 *
	4-6 days	100	4.477	0.547		
	7-9 days	35	4.653	0.460		
	10 days and more	21	4.272	0.328		
	Total	175	4.476	0.519		
Approach of care	1-3 days	19	3.947	0.506	0.823	0.483
	4-6 days	100	4.097	0.501		
	7-9 days	35	4.138	0.420		
	10 days and more	21	4.020	0.399		
	Total	175	4.080	0.475		
Hotel services	1-3 days	19	4.355	0.641	1.630	0.184
	4-6 days	100	4.475	0.702		
	7-9 days	35	4.500	0.609		
	10 days and more	21	4.142	0.649		
	Total	175	4.427	0.675		
Total	1-3 days	19	4.177	0.408	1.770	0.155
	4-6 days	100	4.256	0.452		
	7-9 days	35	4.400	0.375		
	10 days and more	21	4.190	0.256		
	Total	175	4.268	0.417		

Table (4.38b): Post hoc LSD test for length of stay in the hospital

Domain	Length of stay in the hospital		Mean Difference	P value
Information and communication	7 - 9 days	1 - 3 days	0.334	0.043 *
		4 - 6 days	0.307	0.007 *
		10 days and more	0.215	0.175
Respect and privacy	7 - 9 days	1 - 3 days	0.277	0.059
		4 - 6 days	0.175	0.082
		10 days and more	0.380	0.008 *

Table (4.38a) showed that there were statistically no significant differences in the meeting expectations, hospital culture, approach of care, hotel services domains and the total score of quality health services, while there were statistically significant differences in information and communication domain ($P= 0.048$) and respect and privacy ($P= 0.044$). As demonstrated in table (4.38b), Post hoc LSD test showed that patients who stayed in the hospital for 7 – 9 days expressed statistically significant higher perception about information and communication, and respect and privacy compared to patients who stayed in the hospital 1 – 3 days, and patients who stayed in the hospital for 4 – 6 days.

This result is incongruent with a study conducted by (Abu Hasera, 2016) that found there are no statistically significant differences between the average estimates of the study sample in all areas of the study tool attributed to the number of days of stay in the hospital until the recipient of the service receives the same services and of the same quality, regardless of the length or shortness of her stay in the hospital, that is, the services provided in the hospital are provided based on specific instructions, procedures, and protocols that are not exceeded except when It is in the best interest of the patient.

The researcher attributes that patients who stayed in the hospital for 7 – 9 days expressed statistically significant higher perception about information and communication, and respect and privacy compared to patients who stayed in the hospital 1 – 3 days, and patients who stayed in the hospital for 4 – 6 days. This result showed a high perception in regard to information and communication and respect and privacy and it comes only after the patients stay overnight for long periods of stay and the patient can evaluate the services provided in all respects.

Table (4.39a): Differences in patients' perception about quality of health services related to health status

Health status		n	Mean	SD	F	P value
Meeting expectations	Bad	5	4.120	0.657	3.721	0.006 *
	Fair	6	3.600	0.979		
	Good	44	4.081	0.509		
	Very good	83	4.255	0.597		
	Excellent	37	4.421	0.470		
	Total	175	4.220	0.585		
Information and communication	Bad	5	3.966	0.802	5.938	0.000 *
	Fair	6	3.861	0.859		
	Good	44	4.075	0.577		
	Very good	83	4.275	0.565		
	Excellent	37	4.603	0.373		
	Total	175	4.271	0.582		
Hospital culture	Bad	5	4.066	0.302	2.858	0.025 *
	Fair	6	4.305	0.733		
	Good	44	4.106	0.522		
	Very good	83	4.116	0.471		
	Excellent	37	4.396	0.317		
	Total	175	4.178	0.474		
Respect and privacy	Bad	5	4.200	0.799	5.246	0.001 *
	Fair	6	3.809	1.016		
	Good	44	4.418	0.503		
	Very good	83	4.469	0.497		
	Excellent	37	4.706	0.283		
	Total	175	4.476	0.519		
Approach of care	Bad	5	3.971	0.309	1.966	0.102
	Fair	6	4.071	0.611		
	Good	44	4.016	0.410		
	Very good	83	4.036	0.526		
	Excellent	37	4.270	0.386		
	Total	175	4.080	0.475		
Hotel services	Bad	5	4.150	0.651	4.337	0.002 *
	Fair	6	3.416	1.114		
	Good	44	4.511	0.602		
	Very good	83	4.418	0.630		
	Excellent	37	4.547	0.666		
	Total	175	4.427	0.675		
Total	Bad	5	4.074	0.501	5.218	0.001 *
	Fair	6	3.881	0.778		
	Good	44	4.188	0.406		
	Very good	83	4.252	0.417		
	Excellent	37	4.489	0.213		
	Total	175	4.268	0.417		

Table (4.39b): Post hoc LSD test for health status

Domain	Health status		Mean Difference	P value
Meeting expectations	Fair	Bad	-0.520	0.133
		Good	-0.481	0.053
		Very good	-0.655	0.007 *
		Excellent	-0.821	0.001 *
Information and communication	Fair	Bad	-0.105	0.753
		Good	-0.214	0.373
		Very good	-0.413	0.078
		Excellent	-0.742	0.003 *
Hospital culture	Fair	Bad	0.238	0.397
		Good	0.199	0.325
		Very good	-0.189	0.337
		Excellent	-0.090	0.657
Respect and privacy	Fair	Bad	-0.390	0.195
		Good	-0.609	0.005 *
		Very good	-0.660	0.002 *
		Excellent	-0.897	0.000 *
Hotel services	Fair	Bad	-0.733	0.065
		Good	-1.094	0.000 *
		Very good	-1.002	0.000 *
		Excellent	-1.130	0.000 *
Total score	Fair	Bad	-0.193	0.425
		Good	-0.307	0.079
		Very good	-0.0371	0.029 *
		Excellent	-0.608	0.001 *

Table (4.39a) showed that there were statistically significant differences in meeting expectations ($P= 0.006$), information and communication ($P= 0.000$), hospital culture ($P= 0.025$), respect and privacy ($P= 0.001$), hotel services ($P= 0.002$), and total score ($P= 0.001$). as presented in table (4.39b), Post hoc LSD test showed that patients who described their health as fair expressed significant lower perception about meeting expectations, information and communication, hospital culture, respect and privacy, hotel services, and total quality of health services compared to patients who described their health as very good and patients who described their health as excellent.

The researcher attributed that patient who described their health as fair expressed significantly lower perceptions about meeting expectations, information and communication, hospital culture, respect and privacy, hotel services, and total quality of health services compared to patients who described their health as very good and patients who described their health as excellent. This is due to the nature of the patient who sees that his health condition is acceptable will not be satisfied with the services provided in all their forms and will not give a great perception about the quality of the services provided. This depends on the extent of the person's knowledge of his health condition in the correct manner. with sufficient information about his health status, which necessitated the lack of a good perception of the services provided to him as a patient.

4.3 Database part

4.3.1 Mortality rate

The mortality rate is one of the best hospital quality indicators in the clinical effectiveness domain, and the mortality rate in surgical departments reflects the quality of surgical work performed at SHMC. The mortality rate in surgical departments was 10.6/1000 in 2020 and dropped to 9.5/1000 in 2021. In addition, the mortality rate in 2020 in medical departments was 71.4/1000 and increased to 86.3/1000 in 2021.

The highest mortality rate in 2020 in surgical departments was in the department of general surgery for women, with a rate of 14.8/1000 changing to 14.6/1000 in 2021. The lowest mortality rate in 2020 in surgical departments was in the department of orthopedic surgery for women, with a rate of 0.78/1000, and in the pediatric surgery department, with a rate of 1.4/1000 in 2021.

The highest mortality rate in 2020 in medical departments was in the department of internal medicine for men (A) at 84/1000, then elevated to 105/1000 in 2021. The lowest mortality rate in 2020 in medical departments was in the department of internal medicine for women (B) at a rate of 48.3/1000 and 76.5/1000 in 2021.

The hospital mortality in general, it is found the crude death rates across UK hospitals in 2021 from 3.4% to 13.6% (average for UK is 8.5%) data obtained from UK statistics about hospitals.

The researcher noted that hospital mortality measures the deaths that occur in inside the Al Shifa Medical Complex without enumeration of deaths that occur within 30 days of discharge. and must use Hospital Standardized Mortality Ratio (HSMR) is nowadays used as a hospital quality performance indicator and many hospitals are using it which indicate excellent performance, high concern about patient safety, and increase the confidence in services provided. And it was really difficult to get HSMR at SHMC because a large number of discharge summary don't contain ICD10 codes. However, due to the uncompleted coding of the discharge summary, the researcher found it very difficult to get exact results about the mortality rate for a specific disease. Also the completeness of cause-of death globally is 49% (WHO, 2018c).

The researcher assumes this one of the recommendations to administration to monitor the status of documentation with a lot of concern about ICD10 application so we can get HSMR that can be comparable to international figures.

4.3.2 Readmission rate

Readmission rate is one of the best hospital quality indicators which reveals effectiveness and safety domains. The 30-day readmission rate is rapidly gaining importance as a quality metric and is increasingly being used to evaluate performance.

The result of this indicator shows the readmission rate during the first 30 days of discharge from inpatient 17 medical and surgical departments in the year 2021 with a mean percent of 6.82%. The result in all surgical departments was 6.02% (in all orthopedics departments readmission is 3.48%, all readmission in departments of general surgery is 7.33%, all readmission in departments of specialized surgery is 7.44%, the readmission rate in the pediatric surgery department is 3.68%, the readmission in the thoracic surgery department is 3.2%, and the readmission in the department of burns and plastic surgery is 1.48%). Also, the readmission rate in all medical departments was 7.62 percent.

The highest readmission rate from the surgical departments was in the department of specialties surgery for men (A) and which was 9.25%, and the lowest readmission rate was in the Women's orthopedic department and which was 0.76%. In addition, the highest readmission rate from the medical departments was in the department of internal medicine for men (A) which was 8.87%, and the lowest readmission rate was in the department of

internal medicine for women (B). This result is consistent with a study conducted by (Bernatz & Anderson, 2015) that found, the 30-day readmission rate in surgical departments is between 4.2% and 7.4%, and the significant heterogeneity among studies indicates that there are factors such as demographics, procedure types, and individual institutional factors that are important and affect this outcome variable.

Also, this result is inconsistent with a study conducted by (Bernatz et al., 2015) that found, the overall 30-day readmission rate across all orthopedics was 5.4 percent. Moreover, the result is inconsistent with the study conducted by (Chunyuan Guo¹, Guie Dong¹, Xinling Liang², Zheng Dong¹, 2017) that found the thirty-day unplanned readmission rates were 17.1 percent for medicine, 11.3 percent for surgery and gynecology, 20.6 percent for cardio respiratory, 12.5 percent for cardiovascular, and 13.7 percent for neurology. Moreover, the study is inconsistent with the study conducted by (Robinson et al., 2019) that analyzed the data from 1,781 discharges for 1,410 individual patients who matched inclusion criteria; 456 (27%) were readmitted to the same hospital within 30 days.

Table (4.40): Quality indicators (Mortality rate, Length of stay rate, Readmission rate in year 2020,2021)

Year	2020			2021			
Department	Number of patients	Death rate	Mean stay	Number of patients	Death rate	Mean stay	Readmission
Surgical	12749	10.6/1000	16.76	13776	9.5/1000	14.29 days	6.02%
Medical	8539	71.4/1000	5.87	7973	86.3/1000	7.936 days	7.62%

As shown in the above table, the death rate in the surgical departments was 10.6/1000 patients in 2020 and 9.5/1000 patients in 2021, mean stay in the hospital was 14.29 days, and the rate of readmission was 6.02%.

For the medical departments, the death rate was 71.4/1000 patients in 2020, increased to 86.3/1000 patients in 2021. This result may be attributed to the high number of patients admitted to medical departments during COVID-19 outbreak, which resulted in increase the

number of deaths. Also, the results indicated that mean stay was 5.87 days, increased to 7.936 days in 2021, and readmission rate was 7.62%.

4.3.3 Absenteeism

One of the important components of quality of health care service is ensuring patients' safety and this could be reflected by the number of nursing staff who give the services and the basic education of nursing staff. Absenteeism is referred as failure of employees to report for work when they are scheduled to work, it measures staff orientation and safety.

Absenteeism is a sign of dissatisfaction with a job and can have a high impact on hospital operations. This can lead to higher costs to cover lost wages, an increase in workload for remaining staff, and a decrease in quality of care if key personnel are unavailable. Absence is most disruptive when it is short-term and unpredictable. It also allows less time to adjust schedules, or to take steps to replace absent workers. A study involving one of the largest groups at the hospital (nursing staff and physicians).

After meeting the director of nursing, he reported that "the absenteeism rate is almost non-existent now, and it has been addressed after it had been a major obstacle to the provision of services in the past, an impediment to work and confusion to the workflow and the provision of service to the patient. In addition, after meeting the medical director he said that the allocated number of the physicians and nurses at each department of SHMC is not adequate, which leads to excessive work and early fatigue of the HCP, but the high commitment of the nursing staff and physicians, and knowing in advance any absenteeism will lead to a big deficit in the work with excessive load to remaining staff prevent them of recording absence in spite of their mild health discomfort."

Table (4.41): Absenteeism indicators (Nurses in medical & surgical departments) in year 2021

Indicator	Value
Percent of absent nurses in medical & surgical departments/ year	17.5%
Percent of absent nurses in medical & surgical departments/ month	1.45%
Average absent days / month (from the total working days)	0.122
Average absent days / year (from the total working days)	1.46
Average absent days / nurse (from the total number of nurses)	0.325
Average absent days / nurse (from the absent nurses)	1.86

Total number of nurses in medical & surgical departments = 200 nurses

Total number of working days = $200 \times 22 = 4400$ days / month

Total number of absence days = 65 days / year (5.4 days / month)

Number of absent nurses = 35 nurse (during the year)

This indicator reflects the high moral commitment of the nurse staff at SHMC but it does not mean that the nursing staff is fully satisfied with their work. Due to the researcher's inability to access fixed schedules for doctors inside Al-Shifa Medical Complex, we were unable to know the number of days of absence for physicians, but when we met with the medical director of the complex and asked him about the absence of physicians, he stated that the absence of physicians does not exist and there are no significant absences. The table above shows the days of absence for the nursing class inside the complex.

4.3.4 length of stay

The average length of stay is one of the best hospital quality indicators for performance which reveals efficiency domain. The average length of stay at SHMC was 11.3 days in the year 2020, and it was 11.11 days in the year 2021 which is considered high. The lowest mean stays in 2020 was at departments of specialized surgery for women(A) with an average of 3.51days, and in 2021 the lowest mean stay was in internal medicine for men (A) and it was 2.83 days. Also, the maximum length of stay in 2020 was at internal medicine for women (B) with an average length of stay of 123.6 days, and in 2021 was at orthopedic surgery for men (B) it was 83.8 days.

The average length of stay at surgical departments ranges in 2020 was 16.76 days and in 2021 was 14.29 days which is considered high. Also, the average length of stay at medical departments ranges in 2020 was 5.87 days and in 2021 was 7.936 days.

The average length of stay in a hospital for an inpatient in 2021 in Israel was 6.3 days and, in the USA, it was 6.2 days. In the UK, it was 6.9 days and in France, it was 9.1 days (OECD, 2022).

This result is inconsistent with a study conducted by (AbuSada, 2013) that found the average length of stay at EGH was 4.5 days, and the average length of stay at surgical departments ranges from 4.88 at male surgical to 5.03 at female surgical.

The researcher noted that the length of stay in SHMC with a comparison with the average length of stay indicator in international hospitals, is high and needs more attention for a shorter stay in surgical departments that will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. And the researcher noted that most of the patients are admitted one day before the operation date, which unnecessarily increases the length of stay at the surgical department. And the recommendation is to update the admission procedures and policies related to elective surgery.

Chapter Five

Conclusion and recommendations

5.1 Conclusion and recommendations

To achieve the objectives of this study, the researcher must answer the questions raised in the research work, particularly those concerning the availability of performance indicators at SHMC. Some of them were easily captured via questionnaires, while others, such as medical records and databases, required more effort, searching, and modification.

Examples of available and useful performance indicators from the database and complex reports are the average length of hospital stay and mortality rate, but its needs improvement and extracting the results from the database annually, not just monthly for each ward. Moreover, readmission rates to general wards and absenteeism rates for workers should be part of the assessment of hospital performance.

Infrastructure and work environment are good indicators of Al-Shifa Complex's performance, which reveals effectiveness. Some things had a positive impact on this indicator, including infection control services and waste sorting.

Return to ICU Good indicator of Al-Shifa Complex's performance is easily met from questionnaires that demonstrate effectiveness; it is apparent that there is a healthcare provider capable of working in general wards with cases that were discharged from the ICU. However, it must develop measures that will decrease the number of cases that need to be readmitted to the ICU as well as the availability of beds.

Prophylactic antibiotic availability and use were easily met from questionnaires, but there is a need for more specifications about protocols and implementation of these protocols and the availability of prophylactic drugs in the wards continuously.

Work-related injuries are good indicators of Al-Shifa Medical Complex and its easily met from questionnaires which reveal the staff orientation and safety.

Training performance indicators were easily met from questionnaires and also there was no clear calendar for the training activity as, apart from formal training for trainee residents, these training courses happened on an irregular basis. Also, regarding training for the nursing staff, there are no clear scheduled annual training activities including a nomination for

foreign scientific missions and a nomination for participation and attendance in scientific conferences.

The workload and excessive working hours performance indicators were easily met from questionnaires, and this indicator mandates continuous improvement and searching for solutions to ensure the availability of a sufficient number of healthcare providers to ensure the provision of good health service and give the employees overtime hours to overcome a problem of overload and shortage of healthcare providers.

The management stands at the psychological, economic, and social conditions of the worker performance indicators, which were easily met from questionnaires that reveal the responsive governance and the results mandated continuous improvement. It is necessary to support this direction to build greater confidence with management and healthcare providers.

Availability of medication and medical supplies performance indicators were easily met from questionnaires which reveal the responsive governance the results mandate continuous monitoring of availability of medication and medical supplies in the wards especially availability of permanent stock in wards.

From this research study about patient perception, the mean percent was 85.2%, which indicated a high level of patient satisfaction with the quality of health services provided at SHMC, but in some domains of quality services needs to be stressed and modified, especially in the approach of care domain in the process of admission to the hospital and discharge process. It must be easy and without obstacles. Furthermore, healthcare provider perception in this study had a mean percent of 57.6%, which indicated that the healthcare providers' perception of the quality of health services provided at Al Shifa Medical Complex was at a moderate level.

To answer a very important question of the study is the quality of services at SHMC match with the WHO PATH guidelines? The researcher can conclude that the indicators at SHMC comply with the conceptual framework of WHO PATH guidelines with some modification of indicators that was accessible, available, and achievable.

The researcher is certain that when you enter SHMC you will see the writing that the mission of this complex is quality of health care services and this was reflected by the perception of top managers and by the quality of service provided.

5.2 Recommendations

1. SHMC should invest more in determining quality indicators which are easily captured, met, comparable and reflective
2. Effectiveness-related indicators in the infrastructure and work environment are good in surgical departments but require reinforcement in medical departments. As well, prophylactic antibiotic use and availability need more monitoring, and the prophylactic antibiotics in these wards must be available continually.
3. Staff orientation and safety indicators in the work-related injury are good. But in the training, they need redesign because the training wasn't adequately systematized and required framing and clearly scheduled annual training activities. Also, the workload and excessive work hours need more solutions and continuous improvement.
4. Responsive governance related indicators in management stands at the psychological, economic and social conditions of the worker are good but require reinforcement. But in availability of medication and medical supplies need more solutions of a shortage of these supplies with the relevant authorities.
5. Efficiency indicators in the length of stay require more modification to produce unambiguous percentages for the entire year and for all departments, rather than monthly percentages as is now the case.
6. Policies and processes regarding admission, discharge, are important issues that require redesign.
7. The database and the information system in place need further development.
8. Readmission rates to general wards and absenteeism rates for workers should be part of the assessment indicator for hospital performance.
9. Enhance the completeness of the discharge summary of deaths within departments using ICD-10 codes to determine the cause of death.
10. Patients' perspectives about services especially approach of care require more attention especially in bought the drugs from the patient's own account.
11. Mortality related indicators require more standardization using standardized mortality rates instead of crude mortality rates.

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Annexes

Annex (1) An official letter of request

Al-Quds University
Jerusalem
School of Public Health



جامعة القدس
القدس
كلية الصحة العامة
التاريخ: 2021/10/27

حضرة الأستاذ/ جهاد عكاشة المحترم
مدير دائرة البحث الصحي-وزارة الصحة

تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب خالد السلطي

نشكر لكم دعمكم الدائم لمسيرة العلم والتعليم وخصوصاً دعم كلية الصحة العامة وطلابها، ونود إعلامكم بأن الطالب المذكور أعلاه يقوم بعمل بحث كمتطلب للحصول على درجة الماجستير في السياسات والإدارة الصحية- مسار الجودة وسلامة المريض بعنوان:

“Quality of Healthcare Services at Al - Shifa Medical Complex in the Gaza Strip”

وعليه نرجو التكرم بالموافقة على تسهيل مهمة الطالب في إنجاز هذا البحث حيث أن الفئة المستهدفة هم الكوادر الطبية من أطباء وقمريض العاملين في أقسام الجراحة والباطنة بمجمع الشفاء الطبي وايضا المرضى في تلك الاقسام. حيث سيتم جمع المعلومات من خلال استبانة تم اعدادها ، بالإضافة إلى الاستعانة بالملفات والبيانات المؤرشفة في قاعدة البيانات الخاصة بمجمع الشفاء.

واقبلوا فائق التحية و الاحترام،،،



د. بسام أبو حمد

منسق عام برامج الصحة العامة
فرع غزة

نسخة:

- الملحق

Jerusalem Branch/Telefax 02-2799234
Gaza Branch/Telefax 08-2644220 -2644210
P.O. box 51000 Jerusalem

فرع القدس / تلفاكس 02-2799234
فرع غزة / تلفاكس 08-2644220-2644210
ص.ب. 51000 القدس

Annex (2): Helsinki committee approval



المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee

For Ethical Approval

Date: 15/02/2021 **Number:** PHRC/HC/859/21

Name: Khalid Ishaq Abd Qader Alsalty **الاسم:**

We would like to inform you that the committee had discussed the proposal of your study about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Quality of Healthcare Services at Al-Shifa Medical Complex in the Gaza Strip

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/859/21 in its meeting on 15/02/2021

و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member  **Member**  **Chairman** 

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

E-Mail: pal.phrc@gmail.com

Gaza - Palestine غزة - فلسطين
شارع النصر - مفترق العيون

Annex (3): Agreement letter from director of the department of scientific research at the MOH

State of Palestine
Ministry of health



دولة فلسطين
وزارة الصحة

التاريخ: 28/10/2021
رقم المراسلة: 806527

السيد : جهاد عبدالقادر عكاشه المحترم

مدير دائرة الإدارة العامة للوحدات الإدارية المساعدة /وزارة الصحة

السلام عليكم ,,,

الموضوع/ تسهيل مهمة الباحث خالد السلطي

التفاصيل //

السلام عليكم
نهدىكم أطيب التحيات ونود منكم تسهيل مهمة الباحث/ة خالد اسحق السلطي الملتحق/ة ببرنامج ماجستير في الإدارة والسياسات الصحية-جامعة القدس أبو ديس في إجراء بحث بعنوان
Quality of Healthcare Services at Al-Shifa Medical Complex in the Gaza Strip
حيث الباحث/ة بحاجة لتعبئة استبانة عشوائية لعدد من العاملين ومطلقي الخدمة في مرافق وزارة الصحة (مجمع الشفاء الطبي)، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية وتفضلوا بقبول التحية والتقدير،
ملاحظة / تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 3 أشهر من تاريخه

علي حسن البليسي
حكيم جامعي





لإفادة (28/10/2021) ← جهاد عبد القادر مصطفى عكاشه (مدير دائرة)

لإفادة (28/10/2021) ← جهاد عبد القادر مصطفى عكاشه (مدير دائرة)

لإفادة (28/10/2021) ← جهاد عبد القادر مصطفى عكاشه (مدير دائرة)

لإفادة (28/10/2021) ← جهاد عبد القادر مصطفى عكاشه (مدير دائرة)

للتعميم (29/10/2021) ← هاني سلطان ارميح الوحيددي (مدير وحدة)

للتعميم (29/10/2021) ← هاني سلطان ارميح الوحيددي (مدير وحدة)

إجراءاتكم
بالخصوص (31/10/2021) ← عبد السلام محمد عيد صباح (مدير عام بالوزارة)

■ علي حسن عبد القادر البليسي (حكيم جامعي)
ملاحظات التأشير ::

■ علي حسن عبد القادر البليسي (حكيم جامعي)
ملاحظات التأشير ::

■ علي حسن عبد القادر البليسي (حكيم جامعي)
ملاحظات التأشير ::

■ علي حسن عبد القادر البليسي (حكيم جامعي)
ملاحظات التأشير ::

■ جهاد عبد القادر مصطفى عكاشه (مدير دائرة)
ملاحظات التأشير ::

■ جهاد عبد القادر مصطفى عكاشه (مدير دائرة)
ملاحظات التأشير ::

■ هاني سلطان ارميح الوحيددي (مدير وحدة)

التحويلات

Gaza

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غزة
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فاكس. (+970) 8-2826295

Annex (4) Arabic patient's questionnaire



طلب الموافقة

الأخوات والأخوة الأعزاء:

أرجو التكرم بالإجابة على أسئلة الاستبيان الذي تم إعداده لجمع المعلومات اللازمة لتقييم وتقويم الخدمات الصحية المقدمة في مجمع الشفاء الطبي
يتم عمل هذا البحث كمتطلب تخرج لإنهاء درجة الماجستير في السياسات الإدارية الصحية/ مسار الجودة وسلامة المريض - كلية الصحة العامة - جامعة القدس/ أبوديس.

والدراسة بعنوان /" جودة خدمات الرعاية الصحية المقدمة بمجمع الشفاء الطبي بقطاع غزة"

إن تعاونكم وموافقتكم على المشاركة والإجابة على أسئلة الاستبيان سيكون له أهمية بالغة لإنجاز هذا البحث، وكذلك للارتقاء بالخدمات الصحية في مجمع الشفاء الطبي.
كما أن المعلومات الخاصة بكم وبناتج البحث ستكون في سرية تامة ولكم مطلق الحرية في المشاركة أو عدم المشاركة دون أن يكون هناك أي ضرر يلحق بكم في حال عدم المشاركة أو أي عائد مادي للمشاركة.

شاكرين تعاونكم
الباحث خالد اسحق السلطي

البيانات الشخصية:

هذه الأسئلة هي عنك. لمساعدتنا على فهم إجاباتك على أسئلة أخرى، نحن نحتاج بعض المعلومات الشخصية عنك.

1- الجنس: ☐ ذكر ☐ أنثى

2- العمر: -----

3- الحالة الاجتماعية: ☐ أعزب ☐ متزوج ☐ مطلق ☐ أرمل

4- مكان الإقامة:

☐ محافظة غزة ☐ محافظة الشمال ☐ محافظة الوسطى ☐ محافظة خان يونس ☐ محافظة رفح

5- المواطنة: ☐ لاجئ ☐ غير لاجئ

6- المستوى التعليمي الذي أنهيت:

☐ أمي ☐ ابتدائي ☐ إعدادي ☐ ثانوي ☐ جامعي

7- المهنة: ☐ لا أعمل ☐ أعمل موظف ☐ أعمال حرة

8- تغطية مصروفات العلاج في هذه المستشفى من خلال:

☐ تأمين صحي خاص ☐ تأمين صحي حكومي ☐ تأمين صحي عسكري ☐ تأمين شؤون اجتماعية

☐ تأمين نقابي ☐ من حسابي الخاص ☐ آخر

9- هل هذه أول مرة تدخل/ي فيها هذه المستشفى كمريض؟ ☐ نعم ☐ لا

10- إذا كانت الإجابة "لا" فما عدد مرات الدخول السابقة للمستشفى؟ -----

11- دخولي للمستشفى كان بشكل: ☐ طارئ ☐ العيادة الخارجية ☐ محول من عيادة خاصة

12- قسم الدخول: ☐ باطنه ☐ جراحة

13- ما عدد الأيام التي مكثتها في المستشفى هذه المرة؟ -----

14- بشكل عام، كيف تقيم صحتك:

☐ ممتاز ☐ جيد جدا ☐ جيد ☐ مقبول ☐ سيئ

15- السؤال التالي يتم الإجابة عليه من قبل المرضى الذين تم إجراء عمليات جراحية لهم

- هل تم تحديد موعد مسبق لإجراء العملية الجراحية نعم-----لا-----

- هل تم إجراء العملية حسب الموعد المحدد نعم-----لا-----

- هل تم تأجيل موعد العملية نعم-----لا----- في حالة الإجابة بنعمكم عدد مرات التأجيل.....

- هلحدث أي مضاعفات بعد العملية نعم-----لا----- في حالة الإجابة بنعم ما هو نوع المضاعفات التي

حدثت.....

من فضلك ضع علامة على خيار واحد أمام كل سؤال:

م	الأسئلة	أوافق بشدة	أوافق	غير متأكد	لا أوافق	لا أوافق بشدة
المحور الأول: لقاء التوقعات Meeting Expectation						
1	تجربتي كانت جيدة بالنسبة للعناية والخدمة الصحية المقدمة لي في هذه المستشفى.					
2	تلقيت الخدمات الصحية التي كنت أتوقعها.					
3	حاجتي للأدوية المخففة للألم أخذت بعين الاعتبار.					
4	تلقيت وسائل مختلفة لتخفيف الألم.					
5	معايير تقديم الخدمة التي تعرفت عليها من خلال طاقم المستشفى كانت ممتازة.					
المحور الثاني: المعلومات والتواصل Information and Communication						
1	تم إشراكي في اتخاذ القرارات ذات العلاقة بالعناية بحالتي					
2	تلقيت معلومات كافية حول حالتي الصحية.					
3	تم تزويدي بشرح وافي بالنسبة للعمليات والعناية التي قدمت لي من قبل مقدمي الخدمة الصحية.					
4	طاقم المستشفى كان يعرفني بنفسه.					
5	تلقيت الإجابات المرضية والكافية عن أسئلتني من مقدمي الخدمة الصحية.					
6	أشعر بالتقارب بيني وبين مقدمي الخدمة الصحية.					
المحور الثالث: ثقافة المستشفى Hospital Culture						
1	طاقم المستشفى يعاملون المرضى بالمساواة.					
2	طاقم المستشفى يلبي طلباتي بسرعة.					
3	طاقم المستشفى يعملون معاً كفريق واحد.					
4	تم تقديم الخدمة الصحية لي بالشكل المناسب					
5	الفحوصات الطبية اللازمة لتقديم الخدمة الصحية كانت متوفرة					
6	الأجهزة الطبية اللازمة لتقديم الخدمة الصحية كانت متوفرة					
المحور الرابع: الاحترام والخصوصية Respect and Privacy						
1	أشعر بالاهتمام والمتابعة من قبل الطاقم العامل في القسم بحالتي.					
2	أشعر بأن طاقم المستشفى يهتم بما أقوله.					
3	طاقم المستشفى رغم انشغالهم يعاملوني بطريقة ودية.					
4	شعرت أن طاقم المستشفى يبدي اهتماماً بي كإنسان .					
5	ثقتي عالية بطاقم المستشفى.					
6	مستوى التقدير والاحترام الذي يظهره طاقم المستشفى كان ممتاز.					
7	يحرص طاقم المستشفى على خصوصية المريض عند إجراء الفحوصات.					
المحور الخامس: نهج الرعاية الصحية Approach of care						
1	طاقم المستشفى يلبي طلباتي بشكل أني					
2	لدي شعور بالرضي عن قدرات الطاقم الذي يعالجنني.					
3	طاقم المستشفى يترددون على باستمرار وانتظام.					

م	الأسئلة	أوافق بشدة	أوافق	غير متأكد	لا أوافق	لا أوافق بشدة
4	قمت بشراء أدوية من حسابي الخاص لعدم توفرها داخل المستشفى.					
5	يتم إعطاء الدواء في مواعيد محددة.					
6	عملية الدخول للمستشفى كانت سهلة ودون معيقات.					
7	إجراءات الخروج كانت سهلة ودون معيقات.					
المحور السادس: الخدمات الفندقية Hotel Services						
1	نظافة الحمامات جيدة.					
2	يوجد اهتمام خاص بأمان المريض.					
3	أغطية الأسرة دائما نظيفة.					
4	أغطية الأسرة دائما متوفرة.					

من خلال تجربتك بالإقامة داخل المجمع هل لك أن تحدثني عن الصعوبات التي واجهتك:

.....

.....

.....

هل لك أي اقتراحات تود المشاركة بها

.....

.....

.....

انتهت الأسئلة

شكرا جزيلا لتعاونكم

Annex (5) Arabic healthcare provider questionnaire



استبانة مقدمي الخدمة

بسم الله الرحمن الرحيم

الأخ /ت الكريم /ة:

السلام عليكم ورحمة الله وبركاته،،،،،

أنا الباحث/ خالد إسحق عبد القادر السلطي، أقوم بعمل دراسة لنيل درجة الماجستير في السياسات الإدارية الصحية/ مسار الجودة وسلامة المريض - كلية الصحة العامة - جامعة القدس/ أبو ديس.

والدراسة بعنوان /" جودة خدمات الرعاية الصحية المقدمة بمجمع الشفاء الطبي بقطاع غزة"

يطيب لي أن أضع بين أيديكم هذه الاستبانة التي تهدف إلى الحصول على بعض البيانات الخاصة بتقييم جودة خدمات الرعاية الصحية المقدمة بمجمع الشفاء الطبي فيما يخص دراسة بعنوان:

" جودة خدمات الرعاية الصحية المقدمة بمجمع الشفاء الطبي بقطاع غزة "

باعتبارك من ذوي الخبرة في هذه المستشفى وإيماناً مني بأهمية رأيك في الخدمة المقدمة بالمستشفى ورغم علمي بأن الإجابة عن الأسئلة ستستغرق جزءاً من وقتكم الثمين، إلا أنني أرجو من حضرتكم تحري الدقة في الإجابة عن هذه الأسئلة لما لها من عظيم الأثر في الوصول إلى نتائج قد تؤثر بدرجة كبيرة على سير العمل في مجمع الشفاء.

وتفضلوا بقبول فائق الاحترام والتقدير

شاكرين لكم حسن تعاونكم معنا

الباحث

خالد اسحق السلطي

أولاً- البيانات الشخصية:

الجنس: ☐ ذكر ☐ أنثى

العمر.....

الحالة الاجتماعية: ☐ متزوج/ه ☐ غير متزوج/ه

المؤهل العلمي:

☐ دبلوم متوسط ☐ دبلوم عالي ☐ بكالوريوس ☐ ماجستير/دكتوراه

التخصص: ☐ طبيب/ه ☐ حكيم/ة _مرضى/ة

المسمى الإشرافي:

☐ بدون مسمى ☐ رئيس شعبة ☐ رئيس قسم ☐ مدير

القسم الحالي: ☐ قسم باطنة ☐ قسم جراحة

سنوات الخبرة داخل مجمع الشفاء:.....

سنوات الخبرة داخل القسم الحالي:.....

الدخل الشهري للعائلة.....

ثانيًا. مجالات الاستبانة:

من فضلك ضع/ي علامة ✓ أمام خيار واحد من الخيارات الموضحة أمام كل بيان:

م	البيان	كبيرة جدًا	كبيرة	متوسطة	قليلة	قليلة جدًا
المحور الأول- الفاعلية السريرية (Effectiveness)						
المجال الأول- البنية التحتية وبيئة العمل (Infrastructure and work environment)		درجة الموافقة				
1	الأجهزة والمستلزمات الأساسية اللازمة لتقديم الخدمة متوفرة باستمرار.					
2	الأجهزة والمستلزمات الأساسية اللازمة لتقديم الخدمة حديثة.					
3	يتم متابعة الأجهزة الطبية وصيانتها من الطواقم الفنية بشكل دوري.					
4	تتوفر التحاليل و الفحوصات اللازمة لتقديم الخدمة الصحية.					
5	تتوفر أجهزة حواسيب الكترونية بالشكل الكافي لتقديم الخدمة الصحية داخل المجمع.					
6	يوجد أماكن مجهزة لتقديم الخدمة الصحية بطريقة جيدة ودون أي إزعاج.					
7	يوجد أماكن مخصصة ومجهزة لفترة الراحة الخاصة بالموظفين.					
8	تعدّ الإضاءة الموجودة داخل الأقسام مناسبة لتقديم الخدمة الصحية.					
9	تتوفر أنظمة تهوية مناسبة لتقديم الخدمة الصحية المطلوبة.					
10	تتوفر أنظمة تدفئة مركزية مناسبة لتقديم الخدمة الصحية المطلوبة.					
11	تتوفر دورات مياه مناسبة لاستخدام الموظفين في أقسام المجمع.					
12	تتوفر مياه شرب وخدمات فندقية مناسبة للموظفين في المستشفى.					
13	يتم فرز النفايات الطبية بالشكل الصحيح داخل الأقسام.					
14	تتوفر خدمات مكافحة العدوى داخل المجمع.					
15	تتوفر أجهزة الإنذار الخاص بالحريق داخل أروقة المجمع.					
16	تتوفر معدات وأدوات للتعامل مع الحرائق داخل أروقة المجمع .					
17	تتوفر مخارج طوارئ داخل المجمع.					
18	تتوفر مصاعد كهربائية فعالة بشكل دائم داخل المجمع					
19	تتوفر أنظمة اتصالات فعالة داخل الأقسام.					
20	أعداد الأسرة الموجودة داخل كل غرفة تتناسب مع حجم الغرف.					
المجال الثاني-إعادة دخول المرضى إلى العناية المركزة (Return to ICU)		درجة الموافقة				
1	تحدث مضاعفات لبعض الحالات بعد تخرجها من العناية المركزة للأقسام العامة ويعاد إدخالها للعناية مجددا خلال الأسبوع الأول من تاريخ الخروج.					
2	هناك متابعة حثيثة وتعامل عن قرب للحالات التي تخرج من العناية المركزة من قبل الطاقم الصحي.					
3	الطاقم الصحي لديه الخبرة الكافية للتعامل مع الحالات القادمة من العناية المركزة.					
4	هناك ما يعيق إعادة دخول الحالات إلى العناية المركزة مجددا.					
5	يمكن إيجاد سرير عناية مركزة للحالات التي يتم إعادة إدخالها بكل سهولة.					
المجال الثالث- استخدام المضادات الحيوية الوقائية (Prophylactic antibiotic Availability & use)		درجة الموافقة				
1	المضادات الحيوية الوقائية متوفرة في أقسام الاستقبال والطوارئ.					
2	المضادات الحيوية الوقائية متوفرة حسب الحاجة داخل الأقسام العامة.					

م	البيان	كبيرة جدًا	كبيرة	متوسطة	قليلة	قليلة جدًا
3	يتم توفير المضادات الحيوية الوقائية من الصيدلية بشكل دائم دون إعاقات.					
4	يتم الترشيح في استخدام المضادات الحيوية الوقائية بما لا يتعارض مع مصلحة متلقي الخدمة.					
5	جميع المرضى يتلقون المضادات الحيوية الوقائية حسب بروتوكول موجود داخل المجمع					
المحور الثاني-الأمان لمقدمي الخدمات الصحية و الاهتمام والتوجيه (Staff Orientation & Safety)						
المجال الأول- إصابات العمل (work-related injuries by type)		درجة الموافقة				
1	تم إعلامي بالأمراض المهنية المتوقع الإصابة بها أثناء تأدية العمل.					
2	تم تدريبي لتجنب الإصابات الناتجة عن أداء عملي.					
3	تلقيت التغطيات اللازمة للوقاية من الأمراض التي يمكن الإصابة بها.					
4	يتم توثيق إصابات العمل لدى مسؤول السلامة في المجمع.					
5	تعرضت لإصابات سابقة أثناء فترة عملي.					
6	يتم تحويل الموظف المصاب لإجراء الفحوصات اللازمة بعد الإصابة.					
7	يتم متابعة حالة الموظف المصاب إكلينيكيًا واتخاذ الإجراءات العلاجية اللازمة له.					
المجال الثاني- التدريب (Training)		درجة الموافقة				
1	أُتقِل التدريب علي احتياجاتي التدريبية بصورة دورية داخل المجمع.					
2	أُتقِل التدريب خارج المجمع لسد الاحتياجات من التدريب الغير متوفرة داخل المجمع .					
3	يتم التدريب اللازم للموظفين حسب احتياجات الموظفين.					
4	أشارك في تحديد احتياجات القسم من التدريب.					
5	يسهم التدريب في تطوير أدائي المهني.					
6	تتابع الإدارة تطبيق ما تم إنجازه في العملية التدريبية.					
7	رُشحت للمشاركة والحضور في المؤتمرات العلمية.					
8	تم ترشيحي لبعثات علمية خارجية.					
المجال الثالث-عبء وزيادة ساعات العمل (Work load and Excessive working hours)		درجة الموافقة				
1	يتوافر عدد كافٍ من مقدمي الخدمات الصحية بما يضمن تقديم خدمة صحية جيدة.					
2	يتم جدولة الدوام بما يضمن تقديم خدمة صحية جيدة.					
3	يتناسب عدد ساعات العمل مع حجم الخدمات المقدمة.					
4	يتم احتساب ساعات العمل الإضافي الخاصة بالموظفين.					
5	تتم جدولة الإجازات السنوية للموظفين بما يتناسب مع ظروف العمل.					
المحور الثالث- إدارة مستجيبة (Responsive Governance)						
المجال الأول- تراعي الإدارة الظروف النفسية والاقتصادية والاجتماعية للعاملين		درجة الموافقة				
(Management stands at the psychological, economic and social conditions of the worker)						
1	تهتم الإدارة بدعم الموظفين نفسيًا.					
2	تهتم الإدارة بدعم الموظفين اجتماعيًا.					

م	البيان	كبيرة جدًا	كبيرة	متوسطة	قليلة	قليلة جدًا
3	تهتم الإدارة بطريقة وهئية هندام الموظفين.					
4	تزودني الإدارة بالتغذية الراجعة عن أدائي المهني وترشدني إلى كيفية التغلب على جوانب الإخفاق في الأداء إن وجدت.					
5	تلتزم الإدارة بوعودها تجاه الموظفين.					
6	تقدر الإدارة العمل الذي أقوم به وتعاملني بكرامة واحترام.					
7	تعطيني الإدارة المرونة لتغيير مناوبتي بعد تبريري سبب التغيير المطلوب.					
المجال الثاني- توافر الأدوية والمهمات الطبية		درجة الموافقة				
(Availability of medication and medical supplies)						
1	تتوافر في الصيدلية الأدوية الأساسية اللازمة لعلاج الحالات المختلفة.					
2	تتوافر في الصيدلية الأدوية غير الأساسية اللازمة لعلاج الحالات المختلفة.					
3	يتم توفير المستلزمات الطبية بكميات تتناسب مع أعداد متلقي الخدمة.					
4	يتم توفير الأدوية للمرضى داخل الأقسام من خلال نظام الجرعة الواحدة كل 24 ساعة (الكاردكس).					
5	يتم توفير المستلزمات الطبية بناء على طلبيات مكتوبة.					
6	يوجد رصيد دائم من الأدوية و المستلزمات الطبية داخل الأقسام (stock).					

للبنود الآتية: أعطِ المستشفى درجة من 1 إلى 10 حسب تصورك عن:

م	البنود	الدرجة 1-10
1	استجابة الإدارة للاحتياجات المهنية للموظفين.	
2	نظام العمل داخل المستشفى.	
3	الأجهزة والأدوات الموجودة داخل المستشفى.	
4	توافر الأدوية داخل المستشفى.	
5	مستوى النظافة داخل المستشفى.	
6	تصميم المستشفى الخارجي مناسب لتقديم الخدمات الصحية.	
7	تصميم المستشفى الداخلي مناسب لتقديم الخدمات الصحية.	
8	توفر أماكن للراحة للموظفين.	
9	توفر أماكن وصالات انتظار للمرضى داخل المجمع.	
10	لوحات التعليمات والإرشادات متوفرة في جميع أنحاء المجمع.	
11	الالتزام بمواعيد مكتوبة لزيارة المرضى داخل المجمع.	
12	توفر رجال الأمن في الأماكن التي بحاجة لذلك داخل المجمع.	
13	وجود أماكن ومصفات للسيارات.	
13	وجود حدائق كافية داخل أسوار المجمع.	
14	يشارك أفراد المجمع بالمناسبات والفعاليات العامة للمجتمع.	

Annex (6) Questions of the interview to the key managers

Qualitative Part

Individual (face-to-face) Interviews to key managers

الأسئلة:

سؤال رقم ١: حدثني عن رأيك عن جودة خدمات الرعاية الصحية المقدمة في أقسام الباطنة والجراحة بمجمع الشفاء الطبي فيما يتعلق بالفاعلية السريرية

1. Tell me about your opinion about the quality of health care services provided in the departments of internal medicine and surgical departments at Al-Shifa Complex in regard to clinical effectiveness"

- ☐ البيئة التحتية وبيئة العمل
- ☐ إعادة الدخول المرضى الى العناية المركزة
- ☐ استخدام المضادات الحيوية الوقائية
- ☐ إعادة الدخول الى الأقسام
- ☐ نسبة حالات الوفاة

سؤال رقم ٢: من خلال تجربتك حدثني عن جودة خدمات الرعاية الصحية في أقسام الباطنة والجراحة بمجمع الشفاء الطبي فيما يتعلق بالأمان والحماية المهنية لمقدمي الخدمات الطبية والاهتمام والتوجيه؟

Through your experience, tell me about the quality of health care services in the departments of internal medicine and surgical departments at Al-Shifa Medical Complex in regard to safety&Staff orientation

- ☐ اصابات العمل
- ☐ التدريب
- ☐ غياب الموظفين
- ☐ عبي وزيادة ساعات العمل

سؤال رقم ٣: حدثني عن رأيك عن جودة خدمات الرعاية الصحية في أقسام الباطنة والجراحة بمجمع الشفاء الطبي فيما يتعلق بالإدارة المستجيبة؟

1. Tell me about your opinion about the quality of health care services in the departments of internal medicine and surgical departments at Al-Shifa Medical Complex in regard to responsive governance?

- تراعى الإدارة الظروف النفسية والاقتصادية والاجتماعية للعاملين
- توفر الادوية والمهمات الطبية

سؤال رقم ٤: حدثني عن رأيك عن جودة خدمات الرعاية الصحية في أقسام الباطنة والجراحة بمجمع الشفاء الطبي فيما يتعلق :

- | | |
|---------------------------------|------------------------------|
| - Meeting expectations | توقعات الخدمة |
| - Information and communication | المعلومات والتواصل مع المرضى |
| - Hospital culture | ثقافة المجمع |
| - Respect and privacy | الاحترام والخصوصية |
| - Approach of care | نهج الرعاية الصحية |
| - Hotel services | الخدمات الفندقية |

سؤال رقم ٥: برأيك ما هي مناطق القوة والضعف المتعلقة بجودة خدمات الرعاية الصحية في أقسام الباطنة والجراحة بمجمع الشفاء الطبي؟

Annex (7) Estimated Time table

<div>Month</div> <div>Activity</div>	Duration	Jan/2020	August 2021	Sept /2021	Oct 2021	Nov /2021	Jan/2022	/2022Feb.	March	April/2022	May /2022	Jun /2022	July /2022	August /2022	Sept /2022
Proposal defense and approval															
Questionnaires building	2														
Pilot study	1														
Modifications	1														
Identify research area	2 weeks														
Data collection	7mont														
Literature review	8														
Data Entry	2mont														
Data Analysis	2														
Research Writing	3														

Annex (8) Data of database indicators

Year	2020			2021			
Department	Total case	Death No.	Length of stay	Total case	Death no.	Length of stay	Readmission
General surgery for men	1897	18	4.04	1823	26	4.09	119
General surgery for woman	1886	28	4.06	1917	28	3.99	157
Orthopedics surgery for Men's A	1534	6	4.99	1605	7	4.77	70
orthopedic surgery for Men's B	9	--	689.4	74	1	83.8	4
Orthopedic Surgery for woman	1273	1	6.3	1360	3	5.9	10
Men's surgery specialties A	1631	21	4.02	1791	3	3.66	168
surgery specialties for Men's B	918	9	7.15	1156	16	5.68	98
Women surgery specialties A	1764	17	3.51	1717	23	3.61	125
surgery specialties for Woman B	-	-	-	397	1	11.95	19
Pediatric surgery	1460	10	5	1367	2	5.39	56
Thoracic surgery	56	1	65.1	250	12	14.6	8
Plastic surgery and burns	321	22	11.3	269	9	13.5	4
Chest's diseases	1284	82	7.1	792	70	11.5	50
Medical department for woman A	2758	209	2.9	2302	227	3.48	201
Medical department for woman B	62	3	123.6	431	33	17.7	24
Medical departementents for men	2688	226	2.85	2699	285	2.83	255
Cardiology	1747	90	4.17	1749	73	4.17	113
Total	21288	734		21699	819		1481

Annex (9) Data of absenteeism indicator for nurses in 2021

Month	No. of absenteeism day	No. of absenteeism nurse
Jan.	5	3
Feb.	1	1
Mar.	7	3
Apr.	5	4
May	6	4
Jun.	8	2
Jul.	4	3
Aug.	5	3
Sept.	7	3
Oct.	6	4
Nov.	7	2
Dec.	4	3
Total	65 days	35 Nurse

Annex (10) The internal consistency and reliability by Cronbache alpha method for healthcare provider and patient's questionnaires

1. Health care providers Questionnaire

a. Validity

Internal consistency

The researcher used Pearson correlation test to find out the correlation score between each item and the total score of the domain it belongs to. The results are presented in the following tables.

Table (1): Correlation between each item and the total score of work environment domain

No.	Items of work environment domain	Correlation value
1	Equipment and basic supplies needed to provide the services are available constantly	0.659 **
2	The equipment and supplies needed to provide the services are modern	0.683 **
3	Medical devices are monitored and maintained by maintenance staff regularly	0.576 **
4	The needed diagnostic analysis and examinations are available	0.596 **
5	There is adequate computers that assist in providing health services	0.676 **
6	There are places equipped to provide health service in a good manner and without any disturbance	0.741 **
7	There are designated and equipped places for the staff's rest period	0.675 **
8	The illumination inside the departments is appropriate to provide health services	0.695 **
9	Appropriate ventilation systems are available to provide the required health service	0.714 **

10	Suitable central heating systems are available to provide the required health service	0.655 **
11	Toilets are suitable for the use of hospital staff are available	0.727 **
12	Drinking water and adequate hotel services are available for the hospital staff	0.636 **
13	Medical waste is properly sorted in the department	0.602 **
14	Infection control services are available within the complex	0.592 **
15	Fire alarms are available in the corridors of the complex	0.714 **
16	Equipment and tools are available to deal with fires within the corridors of the complex	0.794 **
17	There are emergency exits inside the complex	0.783 **
18	Efficient electric elevators are available within the complex	0.722 **
19	Effective communication systems are available within departments	0.734 **
20	The number of beds in each room is proportional to the size of the rooms	0.682 **

**Significant at 0.01

Table (1) showed that all the items have statistically significant correlation at 0.01 with the total score of the work environment domain.

Table (2): Correlation between each item and the total score of return to ICU domain

No.	Items of return to ICU domain	Correlation value
1	Complications occur for some cases after they are discharged from the ICU to the general departments and are re-entered for ICU again during the first week of the date of discharge	0.593 **
2	There is vigorous follow-up and close treatment of cases that are out of ICU by the health staff	0.664 **
3	The health staff has sufficient experience to deal with cases coming from ICU	0.687 **
4	There is a reason to re-enter the ICU again	0.472 **
5	An ICU bed can be easily found for re-entry cases	0.591 **

**Significant at 0.01

Table (2) showed that all the items have statistically significant correlation at 0.01 with the total score of the return to ICU domain.

Table (3): Correlation between each item and the total score of Prophylactic antibiotic availability and use domain

No.	Items of Prophylactic antibiotic availability and use	Correlation value
1	Prophylactic antibiotics are available in the reception and emergency departments.	0.744 **
2	Prophylactic antibiotics are available as needed within the general departments.	0.865 **
3	Prophylactic antibiotics are always provided from the pharmacy without hindrances.	0.876 **
4	The use of preventive antibiotics is rationalized in a manner that does not conflict with the interest of the recipients of the service.	0.785 **
5	All patients receive prophylactic antibiotics according to an existing protocol inside the complex	0.830 **

**Significant at 0.01

Table (3) showed that all the items have statistically significant correlation at 0.01 with the total score of the Prophylactic antibiotic availability and use domain.

Table (4): Correlation between each item and the total score of work-related injuries domain

No.	Items of work-related injuries domain	Correlation value
1	I was informed of the expected occupational diseases while on the job.	0.889 **
2	I was trained to avoid injuries resulting from my work performance.	0.904 **
3	I received the necessary vaccination to prevent possible diseases	0.821 **
4	Work injuries are documented by the safety supervisor at the complex	0.921 **
5	I had previous injuries during my work	0.569 **
6	The injured employee is transferred to conduct the necessary examinations after the injury	0.902 **
7	The condition of the injured employee is followed up clinically and the necessary remedial measures are taken	0.839 **

**Significant at 0.01

Table (4) showed that all the items have statistically significant correlation at 0.01 with the total score of the work-related injuries domain.

Table (5): Correlation between each item and the total score of training domain

No.	Items of training domain	Correlation value
1	I receive training according to my needs periodically within the complex.	0.874 **
2	I receive training on my training needs periodically within the complex.	0.851 **
3	The necessary training of the employees is done according to the needs of the employees.	0.892 **
4	I participate in determining the department's training needs.	0.867 **
5	Training contributes to the development of my professional performance.	0.715 **
6	The administration follows up on the implementation of what has been achieved in the training process.	0.865 **
7	Nominated for participation and attendance in scientific conferences.	0.810 **
8	I was nominated for foreign scientific missions.	0.742 **

**Significant at 0.01

Table (5) showed that all the items have statistically significant correlation at 0.01 with the total score of the training domain.

Table (6): Correlation between each item and the total score of workload and excessive working hours domain

No.	Items of workload and excessive working hours	Correlation value
1	A sufficient number of health service providers are available to ensure the provision of a good health service.	0.928 **
2	The hours are scheduled to ensure the provision of a good health service.	0.908 **
3	The number of working hours is proportional to the volume of services provided.	0.927 **
4	Employees' overtime hours are calculated.	0.890 **
5	Annual vacations are scheduled for employees in proportion to work conditions	0.891 **

**Significant at 0.01

Table (6) showed that all the items have statistically significant correlation at 0.01 with the total score of the workload and excessive working hours domain.

Table (7): Correlation between each item and the total score of management stands at the psychological, economic and social conditions of the worker domain

No.	Item of management stands at the psychological, economic and social conditions of the worker domain	Correlation value
1	Management is concerned with supporting employees psychologically.	0.888 **
2	Management is concerned with supporting the employees socially.	0.905 **
3	Management is concerned with the way employees are dressed.	0.792 **
4	The management provides me with feedback on my professional performance and guides me on how to overcome the failure aspects, if happen.	0.836 **
5	Management sticks to its promises to employees.	0.909 **
6	Management appreciates the work I do and treats me with dignity and respect.	0.875 **
7	Management gives me the flexibility to change my shift after I have justified the reason for the change required.	0.843 **

**Significant at 0.01

Table (7) showed that all the items have statistically significant correlation at 0.01 with the total score of the management stands at the psychological, economic and social conditions of the worker domain.

Table (8): Correlation between each item and the total score of availability of medication and medical supplies domain

No.	Items of availability of medication and medical supplies domain	Correlation domain
1	The basic medicines needed to treat different conditions are available in the pharmacy.	0.839 **
2	The non-essential medicines needed to treat different conditions are available in the pharmacy.	0.880 **
3	Medical supplies are provided in quantities commensurate with the number of service recipients.	0.862 **
4	Medicines are provided to patients in the departments through a single dose system every 24 hours (Kardex).	0.832 **
5	Medical supplies are provided on written orders.	0.880 **
6	There is a permanent stock of medicines and medical supplies within the stock sections.	0.709 **

**Significant at 0.01

Table (8) showed that all the items have statistically significant correlation at 0.01 with the total score of the availability of medication and medical supplies domain.

Construct validity

The researcher used Pearson correlation test to find out the correlation between the total score of each domain and the total score of all the domains.

Table (9): Correlation between total score of each domain and the total score of all the domains

Subscale	Domain	Correlation domain
Clinical effectiveness	Infrastructure and work environment	0.705 **
	Return to ICU	0.380 **
	Prophylactic antibiotic availability and use	0.420 **
Staff orientation & safety	Work-related injuries	0.645 **
	Training	0.646 **
	Workload & excessive working hours	0.555 **
Responsive governance	Management stands at the psychological, economic and social conditions of the worker	0.643 **
	Availability of medication and medical supplies	0.370 **

**Significant at 0.01

Table (9) showed that all the domains have statistically significant correlation at 0.01 with the total score of the scale.

Reliability

Reliability is concerned with how consistently the measurement technique measures the concept of interest; a measure is considered reliable if it gives the same results each time the situation is measured. To test reliability, the researcher used Cronbach alpha method as presented below.

Table (10): Reliability of the health care providers questionnaires (Cronbach alpha method)

Scale & subscales	Domain	Number of items	Alpha coefficient
Effectiveness	Infrastructure and work environment	20	0.940
	Return to ICU	5	0.557
	Prophylactic antibiotic availability and its use	5	0.876
	Total	30	0.921
Staff orientation and safety	Work-related injuries	7	0.923
	Training	8	0.932
	Workload and excessive working hours	5	0.945
	Total	20	0.928
Responsive governance	Management stands at the psychological, economic, and social conditions of the worker	7	0.941
	Availability of medication and medical supplies	6	0.910
	Total	13	0.873
Grand total		63	0.940

The researcher calculated the reliability of the HCPs questionnaire by using the Cronbach alpha method. The value of alpha coefficient for all the items of the scales was 0.940, which means that the questionnaires have high reliability.

2. Patients' questionnaire

a. Validity

Internal consistency

The researcher used Pearson correlation test to find out the correlation between each item and the total score of the domain it belongs to. The results are illustrated in the following tables.

Table (11): Correlation between each item and the total score of meeting expectations domain

No.	Items of meeting expectations domain	Correlation domain
1	My experience was good with regard to the health care and service provided to me in this hospital	0.858 **
2	I received the health services I was expecting	0.846 **
3	My need for pain-relieving medication was taken into account	0.877 **
4	I received different means to relieve the pain	0.788 **
5	The standards of service I recognized through the hospital staff were excellent	0.492 **

**Significant at 0.01

Table (11) showed that all the items have statistically significant correlation at 0.01 with the total score of the meeting expectations domain.

Table (12): Correlation between each item and the total score of information & communication domain

No.	Items of information & communication domain	Correlation domain
1	I was involved in making decisions about my health condition	0.817 **
2	I received adequate information about my health condition	0.818 **
3	I was provided with a full explanation of the operations and care provided me by health service providers	0.747 **
4	The hospital staff used to introduce themselves to me	0.725 **
5	I received satisfactory and adequate answers to my questions from health care provider	0.759 **
6	I feel that I'm close to the health providers	0.661 *

**Significant at 0.01

Table (12) showed that all the items have statistically significant correlation at 0.01 with the total score of the information and communication domain.

Table (13): Correlation between each item and the total score of hospital culture domain

No.	Items of hospital culture domain	Correlation domain
1	The hospital staff treat patients equally	0.734 **
2	The hospital staff respond to my requests quickly	0.763 **
3	The hospital staff work together as a team	0.815 **
4	My health service is properly provided	0.851 **
5	The medical equipment needed to provide health services are available	0.323 **
6	The medical examinations necessary to provide the health services are available	0.483 **

**Significant at 0.01

Table (13) showed that all the items have statistically significant correlation at 0.01 with the total score of the hospital culture domain.

Table (14): Correlation between each item and the total score of respect and privacy domain

No.	Items of respect & privacy domain	Correlation domain
1	I feel interest and follow up from the staff about my health	0.739 **
2	I feel that the hospital staff care about what I say	0.753 **
3	The hospital staff treats me in a friendly manner despite their busyness	0.765 **
4	I felt that the hospital staff cared about me as human being	0.751 **
5	I have high confidence in the hospital staff	0.776 **
6	The level of appreciation and respect shown by the hospital staff was excellent	0.799 **
7	The hospital staff is keen on patients' privacy when conducting examinations	0.507 **

**Significant at 0.01

Table (14) showed that all the items have statistically significant correlation at 0.01 with the total score of the respect and privacy domain.

Table (15): Correlation between each item and the total score of approach of care domain

No.	Items of approach of care domain	Correlation domain
1	The hospital staff fulfill my requests in real time	0.520 **
2	I feel satisfied with the capabilities of the staff treating me	0.600 **
3	The hospital staff come to me constantly and regularly	0.627 **
4	I bought drugs from my own account because they weren't available in the hospital	0.349 **
5	The medications are given to me at set time	0.374 **
6	The process of admission to the hospital was easy and without obstacles	0.600 **
7	The discharge process was easy and without obstacles	0.642 **

**Significant at 0.01

Table (15) showed that all the items have statistically significant correlation at 0.01 with the total score of the approach of care domain.

Table (16): Correlation between each item and the total score of hotel services domain

No.	Items of hotel services domain	Correlation domain
1	The cleanliness of the toilets is good	0.883 **
2	There is special concern about patient's safety	0.868 **
3	Bed linen are always clean	0.916 **
4	Bed linen are always available	0.894 **

**Significant at 0.01

Table (16) showed that all the items have statistically significant correlation at 0.01 with the total score of the hotel services domain.

Table (17): Correlation between total score of each domain and the total score of all the domains

Item	Mean	SD	%	Rank
Meeting expectations	4.22	0.585	84.4	4
Information and communication	4.27	0.582	85.4	3
Hospital culture	4.17	0.474	83.4	5
Respect and privacy	4.47	0.519	89.4	1
Approach of care	4.08	0.475	81.6	6
Hotel services	4.42	0.675	88.4	2
Overall satisfaction	4.26	0.417	85.2	

**Significant at 0.01

Table (17) showed that all the domains have statistically significant correlation at 0.01 with the total score of the scale.

Table (18): Reliability of the patients' questionnaires (Cronbache alpha method)

Domain	Number of items	Alpha coefficient
Meeting expectations	5	0.835
Information and communication	6	0.845
Hospital culture	6	0.712
Respect and privacy	7	0.851
Approach of care	7	0.553
Hotel services	4	0.907
Overall	35	0.926

The researcher calculated the reliability of the patients' questionnaire by using the Cronbache alpha method. The value of alpha coefficient for all the items of the scales was 0.926, which means that the questionnaires have high reliability.

Annex (11) The open coding thematic analyze to the transcripts of the in-depth interviews with the four key managers of Al Shifa Medical Complex

Results of interviews

In order to gain more information, the researcher conducted personal interviews with the general director, medical director, director of nursing, and the training and development manager at Al Shifa Medical Complex. The information extracted from the interviews are categorized into the following themes and subthemes.

Theme	Subtheme
Structure & Work environment	Safety measures
	Cleanliness
	Privacy
	Work-related injuries
Logistics and supplies	Shortage of essential drugs
	Inadequate patients' beds
	Inadequate bed linen
	Inadequate supply of consumables
Management & administration	Work overload
	Inadequate staff compared to number of patients
	Fuel & electricity supply
Quality of health services	Communication with patients & their families
	Re-admission to ICU
	Equity in providing health services
	Training of new staff
	Investigation committee for unexpected deaths

Annex (12) List of referees' questionnaires

د. بسام أبو حمد	أستاذ مشارك في كلية الصحة العامة- منسق عام برامج الصحة العامة بجامعة القدس أبو ديس- غزة
د. أسى الإمام	أستاذ مشارك في الصحة ودراسات المجتمع- منسق برامج ماجستير الإدارة والسياسات الصحية- جامعة القدس -أبو ديس
أ.د. معتصم حمدان	أستاذ في السياسات والإدارة الصحية-جامعة القدس أبو ديس
د. خليل شقفة	مدير عام التمريض بقطاع غزة
أ.د. يحيى عابد	أستاذ مشارك وأستاذ علم الوبائيات-كلية الصحة العامة-جامعة القدس أبو ديس
د. حمزة عبد الجواد	نائب عميد-كلية فلسطين للتمريض-منسق برامج ماجستير التمريض بجامعة القدس أبو ديس
د. معتصم صلاح	مدير دائرة الجودة والسياسات في الإدارة العامة للتمريض بغزة
د. محمد الجرجاوي	أستاذ مساعد في العلوم الصحية-مدير دائرة بالإدارة العامة للتمريض
د. عبد الكريم رضوان	نائب عميد كلية التمريض بالجامعة الإسلامية بغزة (أستاذ مشارك بالصحة النفسية المجتمعية)
د. ميسون عبد العزيز	أستاذ مشارك في السياسات الصحية- الجامعة الإسلامية بغزة
د. مازن أبو قمر	أستاذ مساعد بالعلوم الصحية -كلية العلوم الطبية التطبيقية-جامعة الأزهر بغزة
د. احمد نجم	أستاذ مساعد في الصحة المجتمعية- كلية العلوم الطبية التطبيقية -جامعة الأزهر بغزة

Abstract in Arabic

دراسة بعنوان: جودة خدمات الرعاية الصحية المقدمة بمجمع الشفاء الطبي بقطاع غزة

إعداد: أ. خالد اسحق عبد القادر السلطي

إشراف: أ.د. يوسف الجيش

ملخص

إن أساس أداء المستشفى هو الكفاءة المهنية في المعرفة العلمية لطرق التطبيق والتقنيات الحديثة والقدرات المتاحة. كما يوفر تقييم أداء الخدمات الطبية أساساً لاتخاذ قرارات عقلانية وتحسين الخدمة. علاوة على ذلك، فإن تقييم الجودة السريرية للرعاية الصحية يطرح العديد من التحديات المفاهيمية والعملية. وأيضاً يتطلب قاعدة أدلة قوية، يمكن أن تكون بمثابة معيار لتقييم التدخلات.

تهدف هذه الدراسة إلى تقييم جودة خدمات الرعاية الصحية المقدمة في مجمع الشفاء الطبي في قطاع غزة. وتصميم هذه الدراسة كان (كمي ونوعي) لتقييم جودة الخدمات الصحية بأقسام الباطنة والجراحة في مجمع الشفاء الطبي باستخدام مؤشرات منظمة الصحة العالمية PAHT. ولقد تم اختيار العينة بواسطة عينة عشوائية طبقية الاحتمال. تتكون العينة من أربعة عينات طبقية: العينة الطبقة الأولى للمرضى الداخليين المبيتين من مختلف الأجنحة، الباطنة والجراحة، وبتشخيصات مرضية مختلفة، والذين خرجوا من المستشفى خلال فترة الدراسة؛ والعينة الطبقة الثانية هو لمقدمي الرعاية الصحية (الأطباء والتمريض)؛ والعينة الطبقة الثالثة هي سجلات وقواعد البيانات وإحصاءات وتقارير المستشفيات داخل مجمع الشفاء الطبي، وتتألف العينة الطبقة الأخيرة من أربعة من المديرين الرئيسيين في مجمع الشفاء الطبي. العدد الإجمالي للمرضى الداخليين الذين تم أخذ عينات منهم 175 مريضاً. وعينة مقدمي الخدمات الصحية كانت من 220 مشاركاً. اعتمدت الدراسة أداة PATH، التي تستخدمها العديد من الدول الأوروبية لقياس أداء المستشفيات. استخدم الباحث أيضاً استبياناً منظم للتعبن الذاتية لجمع البيانات من مقدمي الرعاية الصحية واستبيان مقابلة منظم مع المرضى المبيتين المنوي خروجهم من أقسام المبيت في مجمع الشفاء الطبي. وبالإضافة إلى ذلك، تم جمع المعلومات والتقارير المتعلقة بقاعدة البيانات. وزيادة على ذلك قد أجريت مقابلات فردية متعمقة مع المديرين الرئيسيين الأربعة. كان معدل استجابة المشاركين في الدراسة 100%. كشفت نتائج هذه الدراسة أن متوسط النسب المئوية لتصورات المرضى الداخليين لخدمات الرعاية الصحية كانت من 81.6% إلى 89.4%. وأشارت النتائج إلى وجود تصور عالي إيجابي لدى المرضى من الخدمات التي تقدم في مجمع الشفاء الطبي. أيضاً، كان أعلى تصور في مجالي الخصوصية والاحترام، بينما كان أدنى تصور في مجال نهج الرعاية الصحية.

علاوة على ذلك، كشفت نتائج هذه الدراسة أن متوسط النسب المئوية فيما يخص تصور مقدمي الرعاية الصحية لخدمات الرعاية الصحية تراوحت بين 57.2% و62%، مما يشير إلى أن تصور مقدمي الرعاية الصحية لخدمات الرعاية الصحية المقدمة في مجمع الشفاء الطبي كان متوسطاً. كان أعلى تصور لمقدمي الرعاية الصحية في مجالات توجيه الموظفين والسلامة، وكان أدنى تصور في مجال الحوكمة المستجيبة. وبالإضافة إلى ذلك، فإن مؤشرات قاعدة البيانات، التي تم الحصول عليها من النظام المحوسب وتقارير مجمع الشفاء الطبي، أظهر أن معدل وفيات المرضى الذين تم إدخالهم إلى المستشفى في عام 2020 كان 10.6/1000 في الأقسام الجراحية و71.4/1000 في الأقسام الباطنية، بينما في عام 2021 كان معدل الوفيات في الأقسام الجراحية 9.5/1000 و86.3/1000 في الأقسام الباطنية. علاوة على ذلك، كان مؤشر مدة الإقامة (LOS) في الأقسام الجراحية في عام 2020 كان 16.76 يوماً و5.87 يوماً في الأقسام الباطنية. بينما في عام 2021، كان 14.29 يوماً للأقسام الجراحية و7.93 يوماً للأقسام الباطنية، كان معدل إعادة الدخول في أقسام مجمع الشفاء الطبي في عام 2021 خلال 30 يوماً بعد الخروج 7.62%. ولقد بلغ معدل التغيب عن العمل في فئة التمريض حوالي 1.46 في المائة من عدد أيام العمل خلال عام 2021، وبلغت نسبة التغيب عن إجمالي عدد طاقم التمريض 17.5 في المائة.