

# Perceptions of Patients regarding Benefits of Accreditation

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**Abstract:** *The paper takes a close look at how patients perceive safety and satisfaction within accredited hospitals in India, placing the discussion within the wider expansion of the country's healthcare sector. It is evident that while growth has been rapid, gaps in quality and access still shape everyday patient experience. Using both primary data from recent fieldwork and secondary sources, the study brings together survey responses and statistical modelling to examine how factors such as waiting time, hospital infrastructure, equipment quality, administrative processes, and ease of navigation inside facilities relate to patient outcomes. The analysis shows that shorter initial assessment time and better physical conditions of hospitals tend to align with higher satisfaction levels, while delays and weak infrastructure quietly erode trust. In my view, what stands out is how strongly patients respond to the built environment and basic service flow, often more than to complex medical processes that remain less visible to them. This suggests that quality improvement in healthcare is not only about clinical excellence but also about the everyday systems patients interact with, from admission to discharge. The study also reflects on safety perceptions, where similar patterns appear, though with some variation across variables. Taken together, the findings offer a grounded view of how accreditation-linked changes are experienced on the ground and where practical attention is still needed.*

**Keywords:** patient satisfaction, patient safety, hospital infrastructure, healthcare quality, accreditation

## 1. Introduction

Healthcare industry has become one of the largest sector of Indian economy. The industry has been growing at a compound annual growth of 22 percent since 2016. The sector alone employs 4.7 million people directly (NITI Ayog, 2021). It's a three tier industry in India, consisting of hospital at primary, secondary and tertiary level, each serving the needs of diverse population of the country. Along with it, the industry comprises of medical devices and equipment, clinical trials, medical tourism, insurance facilities etc. The rising population of the country, lifestyle diseases, growing awareness related to healthcare facilities, digital education, telemedicine, increased investment give an edge to the expansion of the sector.

The industry has various advantages specific to Indian population which contributes to further development of the sector; such as public expenditure on health stood at 2.1% of GDP in 2021-22 (Economic Survey, 2022). In terms of trained medical staff, India has a large supply of allopathic doctors with certified medical qualification. According to IBEF Report (2022), there has been an increase of 0.44 percent of allopathic doctors registered with state and national medical councils from July 2010 to July 2021. Various steps are taken by the Indian government also to strengthen the sector to accommodate varied needs of growing population of the country. In Union Budget of 2022, Rs. 86,200.65 crores were allocated to the Ministry of Health and Family Welfare.

The government has been undertaking various reforms in order to expand and reinforce a better health care regime. One of the major breakthrough of the sector can be traced through the introduction of National Health Policy 2017, which was enforced after 14 years of NHP 2002. The NHP 2017 laid importance on primarily 'access to good quality health care' which is also in lieu with 3<sup>rd</sup> Sustainable Development Goal. The Indian health care system presents varied results in this regard. At one end we see hospitals with gallant

infrastructure, especially in urban areas delivering advance technology medical care, while on the other end we find rather disrupting pictures of shaky health centres in the remote parts. The quality of health facilities differs at large; the effect of stakeholders also is diverse.

To achieve this goal, government of India has taken various steps.

Increasing healthcare budget at state and central level must be a priority by policy makers as it significantly impacts financial protection provided to the citizens to minimise their hardships in paying for medical care (WHO, 2010). One of the major breakthrough of the sector can be traced through the introduction of National Health Policy 2017, which was enforced after 14 years of NHP 2002. The NHP 2017 laid importance on primarily 'access to good quality health care' which is also in lieu with 3<sup>rd</sup> Sustainable Development Goal. Another major step taken by the government for the stability of the sector, was the flagship initiative *Ayushman Bharat*. The policy aims to strengthen all the tiers of health care system through opening up of health and wellness centre (HWC). "Vision 2035 – Monitoring public health in India", a vital function presented across all the three levels of healthcare. The policy includes early diagnosis of diseases and early warning signs of upcoming epidemics. Monitoring includes supervising trends of chronic and acute diseases to come up with timely action.

World Health Organisation identifies health as a human right and tool to ensure social well-being (Mann et. al., 2013). A positive association exists between economic growth and better health determinants. Looking at India's census, it was found out that there is an increasing trend in life expectancy in India to 70 years by 2022. Growing youth and senior citizens (60 years +) are considered to be crucial determinants of growth in health care. It is presumed that India's senior citizen population will see an uprising of 7.4% from 2011 to 2041 (PwC India, 2020). Increasing number of senior citizens

means increasing demand for health care services from demand side. While this also means, upgradation in quality and proper mechanisms in healthcare to meet the above demand. *The Indian healthcare presents a wide array of contrasting results*. At one end we see hospitals with gallant infrastructure, with a range of quality care especially in urban areas delivering advance technology medical facilities, while on the other end we find rather disrupting pictures of shaky health centres in the remote parts. Efforts to improve quality care in India are hindered by methodological factors like lack of reliable data and ways to measure quality care. WHO (2003) ranking on healthcare revealed that out of 191 countries, India ranked 112 in the world. According to the Global Burden of Disease study, India ranks 145<sup>th</sup> among 191 countries in terms of quality and accessibility of healthcare (2018). The challenge of low quality care is not new in India. Various studies of developed and developing nations have pointed out problems pertaining to low quality care and little efforts by providers to ensure quality medical care of their patients. According to Human Development Report (2020), India's Human Development Index rank is 131 out of 189 countries. On key health indicators, India ranks 137 out of 193 countries in under 5 mortality rates (World Bank, 2019). (Gupta et. al, 2018) in their study found out positive correlation between hypertension and healthcare access and quality. Health as defined by, "Universal Health Coverage means access to quality, effective and affordable health services for all, without imposing financial burden" (Lancet, 2014). The most prominent challenges in the healthcare industry are related to availability, accessibility and affordability (Planning Commission, 2011). Some of the challenges highlighted by Planning Commission (2001) were lack of infrastructure, shortage of medicines and trained or skilled personnel in order to deliver and maintain qualitative health care. Indian health care industry is struggling with challenges related to operational care and customer satisfaction (Chiarini & Bracci, 2013).

The current study hence, explores the perceptions of patients with respect to increase in their safety levels and satisfaction levels. Patient safety and satisfaction are treated as dummy when measuring quality improvement. Hence, the objective of the current study is to explore the view points of patients towards their safety and satisfaction by regressing various determinants.

## 2. Review of Literature

Tang et. al. (2004), underlined ten roles in general which is played by government to improve healthcare quality via reducing medical errors and improving patient safety. Some of these roles are purchase and provision of healthcare, availability of quality healthcare to disadvantaged sections of the society, regulation of health care markets, development of healthcare workforce, monitoring of healthcare quality etc. The role of government is paramount because it leads to increased welfare of the people while private stakeholders are more concerned about profit maximisation.

Sequist et. al. (2005), recognised information technology as potential tool to improve quality of American Indian health care. The study discussed potential measures taken by The Indian Health Service to improve quality care of American

Indians. One of the measure was introduction of electronic health record will address quality improvements in a more complete manner. However, high costs and suboptimal designs are potential barriers of introducing these electronic health records.

Duggirala et. al. (2008), used multiple regression analysis to examine the impact of total quality management on hospital performance. The results showed that the 14 dimensions had high and positive correlation with each other. Hospital performance which is operationalised in terms of patient's satisfaction with overall quality care, satisfaction of nurses and doctors with overall hospital functioning came out to be as an important determinant. The results also revealed that financial performance is a factor of hospital performance which must be incorporated in studying impact of quality. The result was backed by various studies Fuentes- Fuentes et. al. (2004); Raju and Lonial (2002); Wilson and Collier (2000); Douglas and Judge (2001).

Sunol and others (2009), studied the relationship between the implementation of quality improvement strategies in hospitals and success in meeting the requirements regarding quality. Data regarding the implementation of seven quality improvement strategies (accreditation, organisational quality management programmes, audit and internal assessment of clinical standards, patient safety systems, clinical practice guidelines, performance indicators and systems for obtaining patients' views) and four dimensions of outputs (clinical, safety, patient-centredness and cross-border patient-centredness) were collected from 389 acute care hospitals in eight EU countries using a web-based questionnaire. Pearson correlation and linear regression models were used to explore associations and relations between quality improvement strategies and achievement of outputs. The results showed positive associations between six internal quality improvement strategies and hospital outputs.

Alkhenizan and Shaw (2011), did a systematic review of literature to evaluate the impact of accreditation programs on the quality of healthcare services using databases such as Medline, Embase, Healthstar and Cinhal. 26 studies assessing the impact of accreditation were recognized. Major studies had their accreditation programs specific to trauma, infection control, acute myocardial infection, surgical care and pain management. The results revealed that these programmes improve quality of health care outcomes.

Leung and others (2013), identified factors that influence implementation of hospital accreditation programmes and to assess the impact of the accreditation process on quality improvement in public hospitals. SWOT analysis were used by the researchers. Increased staff engagement and communication, multidisciplinary team building, positive changes in organisational culture, and enhanced leadership and staff awareness of continuous quality improvement were identified as strengths. Weaknesses included organisational resistance to change, increased staff workload, lack of awareness about continuous quality improvement, insufficient staff training and support for continuous quality improvement, lack of applicable accreditation standards for local use, and lack of performance outcome measures. Opportunities included identification of improvement areas,

enhanced patient safety, additional funding, public recognition, and market advantage. Threats included opportunistic behaviours, funding cuts, lack of incentives for participation, and a regulatory approach to mandatory participation.

Melo (2016), carried out a quantitative analysis to study how quality is improved in practice through accreditation process. The findings of the research indicate that accreditation has led to improved patient safety.

Frank et. al. (2020), studied the role of accreditation in health profession education system. The study found out that, accreditation can increase the quality of standard of various training programs and can also improve learning environments.

Aamir et al. (2023) conducted research in Saudi Arabia to examine the perceptions of healthcare professionals regarding accreditation. The authors bifurcated the professionals according to gender. The results revealed that accreditation results in improved quality care of patients. Wilcoxon rank-sum test and Kruskal-Wallis test were used for this objective. The results also revealed differences in knowledge base gender wise. Male healthcare professionals were more aware about the accreditation as compared to female professionals. The need for training of female staff is emphasised.

### 3. Methodology

The current study hence, explores the perceptions of patients with respect to increase in their safety levels and satisfaction levels. Patient safety and satisfaction are treated as dummy when measuring quality improvement. Hence, the objective of the current study is to explore the view points of patients towards their safety and satisfaction by regressing various determinants. The type of healthcare, the current study has undertaken is Allopathy. It is a term used for conventional or modern western medicine. It is a verification based system where doctors and other healthcare professional treat symptoms using conventional medicines. The sources of data are both primary and secondary in nature. Secondary data on healthcare system, schemes, norms of accreditation and quality etc. is collected from surveys of WHO, NCBI, INDIASTAT, NHM Health Statistics Information Portal, Ministry of health and family welfare, Government of Rajasthan reports and publication on healthcare. Secondary data is collected within a time span of 5 years, that is, 2019-2023. However, primary data which is first hand data in the hands of researcher corresponds to the year 2022-23.

The study is both qualitative and quantitative in nature.

The study has measured the data using a Likert measurement of 1-5, wherein some variables like age of all stakeholders and experience of doctors are continuous in nature. For treating continuous variables, Multinomial Logistic regression was used. Some variables are categorical in nature such as whether the hospital is accredited or not?

Kruskal Wallis test of Hypothesis was used. This test is a multisampling generalization of the two-sample Wilcoxon (Mann-Whitney) rank-sum test.

Ologit fits ordered logit models are also used in the study. Ologit model of ordinal variable dependent variable on the independent variables independent variables. The actual values taken on by the dependent variable are irrelevant, except that larger values are assumed to correspond to "higher" outcomes.

Ordered logit models are used to estimate relationships between an ordinal dependent variable and a set of independent variables. An ordinal variable is a variable that is categorical and ordered, for instance, "poor", "good", and "excellent", which might indicate a person's current health status or the repair record of a car.

## 4. Analysis and Findings

The purpose of the study is to analyse the outcomes of accreditation. For this perceptions of patients been captured regarding the role of accreditation in improving desired outcomes. The quality outcome has dummy of patient safety and patient satisfaction (Ng and Luk, 2019). Other explanatory variable which are qualitative and quantitative in nature have also been studied which will help in establishing relation between patient safety and satisfaction and other variables.

Patient satisfaction is a measure of how happy a patient is with their healthcare. Patient satisfaction and patient experience can be used interchangeably. Patient satisfaction is based on the fact whether their expectations were met by the hospitals or not. Hence, in the current research patients are asked to rate their overall experience or whether their expectations were met. This in turn will lead us to their satisfaction, which is our dependent variable.

Following are some of the explanatory variables explained:

### 1) Time taken by hospital for initial assessment

Patient satisfaction is dependent upon various factors, amongst them one of which is time taken by the hospital in initial assessment. A patient can be asked to wait from 10 to more than 30 minutes. Longer is the time taken for assessment, greater will the dissatisfaction of the patient will be. Patient satisfaction is greatly affected by the long waiting time and other factors such as time taken during consultation, comfort and amenities (Joshi et. al, 2023). Due to heavy flow of patients, sometimes hospital fail to provide initial assessment on time, especially when it comes to emergency department (Madhwal, 2024).

### 2) Medical equipment used by hospital

Medical equipment used by hospitals play essential role in patient satisfaction. The sterilisation of items, life expectancy of each item, the quality and physical condition must be checked before administering on patients. The World Health Organisation focuses on providing quality services to patients under Sustainable Development Goals 2030 (WHO, 2015). The type of medical equipment used by hospitals, show their efficiency, standards and efforts in providing quality services (Szyca et. al., 2012).

### 3) Infrastructure of hospitals

Infrastructure is the key to healthcare improvement. The specific elements of infrastructure include architecture,

designs, clean drinking water facilities, sanitation, proper light and space. Wards and patients must have adequate space, light and good views wherever possible to promote patient friendly and healing environment (Waller and Finn, 2004; National Institute of Health, 2013).

#### 4) Discharge and Billing Process

Hospital administrative processes play an important role in patient safety and satisfaction. A poor discharge and billing process will lead to lower outcomes in terms of patient safety and satisfaction. A safe discharge process is mandatory for preventing poor patient outcomes. Shorter process avoid patients in the hospital longer than necessary.

Administrative process related to patients such as admission, discharge, billing, patient information are vital to improve quality patient care. The admission process involves multiple tasks such as patient registration, patient earlier health records, etc. discharge process on the other hand includes medical treatment review, discharge planning, high priority discharge cases, follow up patient post discharge etc. Effective working of these practices entails high patient care (Lezzoni, 1997; Schwartz et. al., 1999; Bhati et. al. 2023; Cutler 2020)

#### 5) Accessibility and convenience

The ease and convenience with which patients are able to locate areas in hospital and avail the service point towards enhanced patient satisfaction and safety. Previous literature has shown that these domains are preliminary for patient satisfaction and safety (Aloh et. al., 2020; and Aljarallah et. al., 2023). Cronbach's alpha coefficient has been widely used as a measure of reliability. We found alpha ( $\alpha$ ) reliabilities for initial time = 0.80, condition of building = 0.76, medical equipment used by hospitals = 0.84, infrastructure of hospital = 0.80, admin process = 0.70, accessibility and convenience = 0.75, patient satisfaction = 0.76. All these values are above the cutoff point of 0.70 as suggested by Forero, 2014.

Results of Kruskal– Wallis test of hypothesis for Patient Satisfaction shows that condition of building is statistically significant at 1% confidence level ( $p = 0.0001$ ). Further, results show that the type and quality of medical equipment used by hospital is statistically significant at 1% level of significance ( $p = 0.0001$ ), initial assessment time is found to be statistically significant at 10% level ( $p = 0.06$ ), infrastructure of the hospital found to statistically significant at 1% confidence level ( $p = 0.0001$ ), administrative processes such as discharge and billing process is found to be statistically significant at 1% confidence level ( $p = 0.0006$ ), accessibility and convenience is found to be statistically significant at 1% confidence level ( $p = 0.0001$ ), initial assessment time taken by hospital is found to be statistically significant at 10% confidence level ( $p = 0.061$ ).

Results of Kruskal– Wallis test of hypothesis for Patient Satisfaction shows that condition of building is statistically significant at 1% confidence level ( $p = 0.0001$ ). Further, results show that the type and quality of medical equipment used by hospital is statistically significant at 1% level of significance ( $p = 0.0001$ ), initial assessment time is found to be statistically significant at 10% level ( $p = 0.10$ ),

infrastructure of the hospital found to statistically significant at 1% confidence level ( $p = 0.0001$ ), administrative processes such as discharge and billing process is found to be statistically significant at 5% confidence level ( $p = 0.0078$ ), accessibility and convenience is found to be statistically significant at 1% confidence level ( $p = 0.0001$ ), initial assessment time taken by hospital is found to be statistically significant at 10% confidence level ( $p = 0.061$ ).

**Table:** Ordered Logistic Regression for Patient Satisfaction as Dependent Variable

Independent Variables	Patient Satisfaction				
	Average	Good	Very Good	P values	Odds Ratio
Initial Assessment Time	-5.31 (1.15)	-3.29 (.690)	-2.35 (.534)	0.073	0.689
Condition of Building	1.46 (.013)	4.01 (1.31)	5.33 (1.50)	0.000	15.48
Medical Equipment	0.093 (0.706)	2.64 (0.921)	4.85 (1.01)	0.000	21.76
Infrastructure	-3.76 (0.934)	-2.52 (0.571)	2.99 (0.593)	0.000	13.05
Admin Process	0.444 (0.247)	1.60 (1.68)	3.77 (1.45)	0.000	4.67
Accessibility & Convenience	0.376 (0.246)	3.00 (0.593)	4.52 (1.83)	0.000	12.03

( ) represent standard error

Patients have given their responses for patient satisfaction from poor to average to good and to very good. We see that condition of building is a significant explanatory variable ( $p = 0.000$ ) at 1% confidence interval. With each increase of 1 point on the condition of building, patient satisfaction increases by 1.46 point from poor to average, 4.01 points from average to good and 5.33 point from good to very good. The odds ratio show that with increase in one unit in condition of building, patient satisfaction with 'very good' level are 15.48 times higher versus patient satisfaction at 'average and good level'.

Time taken for initial assessment reveals that due to 1 unit increase in initial assessment time, patient satisfaction decreases to 5.31, 3.29 and .235 times respectively. It can be seen that as the initial assessment time keeps on increasing the patient satisfaction goes on decreasing. The variable is statistically significant at 10% interval level (0.073). The odds ratio show that with increase in one unit in initial assessment time, patient satisfaction with 'very good' level are 0.689 times higher versus patient satisfaction at 'average and good level'.

Another important results of the above analysis shows that, condition and quality of medical equipment used by hospitals in treating patients. Patients have given their responses for patient satisfaction from poor to average to good and to very good. We see that with one unit increase in good quality from average or very good quality equipment from good increases patient satisfaction one level up from average to good to 2.64 point and to very good by 4.85 points. The variable is significant at 1% level of confidence ( $p = 0.000$ ). The odds ratio show that with increase in one unit in medical equipment, patient satisfaction with 'very good' level are 21.76 times higher versus patient satisfaction at 'average and good level'.

Better the infrastructure used better is the satisfaction level of patients. It seen that the at lower levels of infrastructure patient show negative relationship with their satisfaction level. As the level of infrastructure increases from good to very good patient satisfaction also rises to 2.99 points, which is further significant at 1% confidence level ( $p=0.000$ ). The odds ratio show that with increase in one unit in infrastructure, patient satisfaction with 'very good' level are 13.05 times higher versus patient satisfaction at 'average and good level'.

We see that admin process is a significant explanatory variable ( $p = 0.000$ ) at 1% confidence interval. With each increase of 1 point on the admin process, patient satisfaction increases by 0.44 point from poor to average, 1.60 points from average to good and 3.77 point from good to very good. The odds ratio show that with increase in one unit in admin process, patient satisfaction with 'very good' level are 4.67 times higher versus patient satisfaction at 'average and good level'.

We see that accessibility and convenience is a significant explanatory variable ( $p = 0.000$ ) at 1% confidence interval. With each increase of 1 point on the accessibility and convenience, patient satisfaction increases by 0.376 point from poor to average, 3.00 points from average to good and 4.52 point from good to very good. The odds ratio show that with increase in one unit in accessibility and convenience, patient satisfaction with 'very good' level are 12.03 times higher versus patient satisfaction at 'average and good level'.

**Table:** Ordered Logistic Regression for Patient Safety as Dependent Variable

Independent Variable	Patient Safety				
	Average	Good	Very Good	P value	Odds Ratio
Initial Assessment Time	-0.299 (0.200)	0.055 (0.507)	-2.19 (0.57)	0.136	0.741
Condition of Building	1.76 (0.428)	2.83 (1.97)	3.57 (1.85)	0.000	5.84
Medical Equipment	-1.29 (0.453)	2.35 (0.820)	4.88 (0.945)	0.004	12.74
Infrastructure	0.590 (0.245)	0.643 (0.654)	2.12 (0.747)	0.000	11.22
Admin Process	0.951 (0.321)	-0.664 (1.58)	0.058 (1.42)	0.003	2.58
Accessibility & Convenience	-5.20 (1.07)	-1.97 (0.80)	0.531 (0.248)	0.001	7.48

( ) represent standard error

Patients have given their responses for patient safety from poor to average to good and to very good. We see that condition of building is a significant explanatory variable ( $p = 0.000$ ) at 1% confidence interval. With each increase of 1 point on the condition of building, patient safety increases by 1.76 point from poor to average, 2.83 points from average to good and 3.57 point from good to very good. The odds ratio show that with increase in one unit in condition of building, patient safety with 'very good' level are 5.84 times higher versus patient safety at 'average and good level'.

Time taken for initial assessment reveals that due to 1 unit increase in initial assessment time, patient safety decreases by 0.299 point from moving one level up (from poor to average).

It can be further seen that, with one unit increase in initial assessment patient safety increases to 0.055 unit from average to good. However, as stark result reveals that patient safety decreases at highest level to 2.19 points. The variable is not significant at any level. The odds ratio show that with increase in one unit in initial assessment time, patient safety with 'very good' level are 0.741 times higher versus patient safety at 'average and good level'.

Another important results of the above analysis shows that, condition and quality of medical equipment used by hospitals in treating patients. Patients have given their responses for patient safety from poor to average to good and to very good. We see that with one unit increase in good quality equipment patient safety decreases to 1.29 points, that is, patient feel there safety were comprises through use of lower quality equipment. However, with further increase in medical equipment of good quality patient safety increases to 2.35 point coming to good from average and finally increases to 4.88 point at the highest level. The variable is significant at 1% level of confidence ( $p=0.004$ ). The odds ratio show that with increase in one unit in medical equipment, patient safety with 'very good' level are 12.74 times higher versus patient safety at 'average and good level'.

Better the infrastructure used better is the safety level of patients. It seen that the at lower levels of infrastructure patient show lower association with their safety by 0.590 points. As the level of infrastructure increases from good to very good patient satisfaction also rises to 2.12 points, which is further significant at 1% confidence level ( $p=0.000$ ). The odds ratio show that with increase in one unit in infrastructure, patient safety with 'very good' level are 11.22 times higher versus patient safety at 'average and good level'.

We see that admin process is a significant explanatory variable ( $p = 0.003$ ) at 1% confidence interval. With each increase of 1 point on the admin process, patient safety increases by 0.951 point from poor to average and 0.058 point good to very good. It can be seen that, one unit increase in discharge process and billing process the safety of patient decreases.

The odds ratio shows that with increase in one unit in admin process, patient safety with 'very good' level are 2.58 times higher versus patient safety at 'average and good level'.

We see that accessibility and convenience is a significant explanatory variable ( $p = 0.001$ ) at 1% confidence interval. It is found to have negative relationship with patient safety with one unit increase in explanatory variable moving from poor to average and average to good. It is positive when there is one unit increase and patient safety increases to very good from good by 0.531 point. The odds ratio shows that with increase in one unit in accessibility and convenience, patient safety with 'very good' level are 7.48 times higher versus patient safety at 'average and good level'.

## 5. Conclusion

It is found through the above analysis that, there are some significant factors or predictor variables that bring about quality improvement in accredited hospitals. It can be seen

from the above analysis that, waiting time or initial assessment time impact patient satisfaction from the patients. When there is one unit increase in initial assessment time of patients (i.e., from score of 4 to score 5) or from good to very good level, patient satisfaction increases to very good level with a score by 0.689 times. Infrastructure also impact patient satisfaction, it is seen that with one unit increase in infrastructure there is increase in patient satisfaction by 13.05 times.

Built in environment of hospital building is seen as a significant indicator of patient satisfaction. Condition of the building include mobility of location, landscape, social and public spaces, homeliness etc. affect patient's perception towards quality care. Hence, it is found out that according to patient 'very good' condition of building increases patient satisfaction by 15.48 times at higher levels. This finding is in lieu with study carry forward by (Douglas, 2005; Alibrandi, 2023). The ease and convenience with which patients are able to locate areas in hospital and avail the service point towards enhanced patient satisfaction and safety. It is found out that patient consider this as a significant indicator of their satisfaction. With increase in ease and convenience patient satisfaction is said to be increased by 12 times.

With ever increasing demand for quality healthcare services, understanding the factors which affect patient satisfaction and safety is crucial for consumers of healthcare. The objective of the study was to explore the perceptions of patients towards patient satisfaction and safety. The results of the study conclude that ease and convenience with which patients are able to locate facilities in the hospital is one of the crucial determinant along with initial assessment time, waiting time, condition of the building and overall infrastructure.

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