

"Evaluating the Effectiveness of Clinical Governance on Medical Service Quality: A Comparative Study in Egyptian Hospitals"

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ABSTRACT:

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Abstract

Evaluating the Effectiveness of Clinical Governance on Medical Service Quality: A Comparative Study in Egyptian Hospitals

Background: Clinical governance (CG) is a framework through which healthcare organizations ensure continuous quality improvement and maintain high standards of care. In October 2022, the Healthcare Authority in Egypt began implementing CG to enhance medical service quality.

Objective: To assess the impact of CG implementation on hospital performance in Port Said Governorate.

Methods: A comparative study was conducted across nine hospitals with 31 operating rooms, 267 inpatient beds, and 83 ICU beds. Fifteen key performance indicators (KPIs) were evaluated over two periods: pre-implementation (January–September 2022) and post-implementation (October 2022–June 2023). Data were analyzed using SPSS v20, with t-test or Mann-Whitney U-test applied; significance was set at $p \leq 0.05$.

Results: Post-CG implementation, significant improvements were noted in laboratory tests performed ($p = 0.004$), occupancy rate ($p = 0.004$), and average length of stay ($p = 0.008$). However, significant increases occurred in hospital-acquired pneumonia ($p = 0.050$), readmission within 30 days ($p = 0.006$), and emergency readmission within 72 hours ($p = 0.031$). No significant differences were found in surgical site infections, surgical procedures, deferred surgeries, patient satisfaction, or healthcare personnel satisfaction.

Conclusion: CG implementation improved resource utilization and selected performance measures. However, rises in certain adverse outcomes highlight the need for targeted quality improvement, continuous monitoring, and enhanced staff training to achieve balanced gains in efficiency and patient safety.

Keywords: Clinical governance, quality improvement, hospital performance, key performance indicators, Egypt

Introduction

Clinical governance (CG), A framework through which healthcare organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical care will flourish. (Sally et al, 1998)

Practicing aspects of clinical governance is required by all members of staff within a healthcare setting, extending to both clinical and non-clinical members of the team. However, providing guidance, leadership and stewardship in these aspects falls to senior, designated members of the medical team. (Patel et al, 2021)

In the contemporary worldwide scenario, governmental as well as private health systems face challenges such as the insufficient response to the health needs of people, and the ever-growing cost, with low productivity and inconstant quality. As healthcare systems are organized to respond to the health needs of people and populations, their management and the organization of care should reflect the principles and the logic through which societies explain and intervene in the health-disease process. (Feuerweker,2005)

It is too early to give a clear answer to whether clinical governance is going to make any difference for the patients, but the systems have been put in place, and there seems to be genuine interest in making it work. (WHO and Ministry of Health and Population, 2021)

The main challenge for the leaders of clinical governance is to change the culture and attitude of staff. This, coupled with the more proactive role adopted by the regulatory bodies should assist with the development and progress of clinical governance and hence to more coordinated and better care of the patients. (Abdel-Razek et al., 2022; Office of Health Economics, 2023)

In Egypt, the health care authority undertakes the responsibility of providing a distinguished health services supported directly from the president of the republic as part of the country 2030 vision. (Riad & Riad Law Firm, 2018)

comprehensive health insurance is a compulsory social solidarity health system in Egypt. It operates in accordance with Law No. 2 of 2018, which stipulates that

comprehensive social health insurance is a compulsory system, based on social solidarity. Its umbrella covers all citizens participating in the system, and the state bears its burdens for those who are unable based on a decision issued by The Prime Minister determines the exemption controls, and the family is the main insurance coverage unit within the system. (Riad & Riad Law Firm, 2018; Andersen Global, 2018)

This system is also based on separating funding from service provision, and the Authority may not provide treatment services or participate in providing them. This system includes an integrated set of diagnostic and treatment services and allows the freedom to choose health service providers other than the family doctor. (Abdel-Razek et al., 2022)

Application of Clinical governance within the healthcare authority was started in October 2022 aiming at improving the quality of the medical services and ensuring its continuous improvement. (Riad & Riad Law Firm, 2018; Andersen Global, 2018)

The present study aimed at showing the impact of applying clinical governance on the performance of different healthcare facilities in Egypt.

Problem Statement

Different field studies showed that healthcare sector in Egypt faces many challenges for example, maintaining a constant and high-quality medical services, insufficient response to the health needs of people, the growing cost of medical services and Low productivity.

In the most recent data from the World Health Organization, Egypt had 445,000 physicians working in the country in 2018, nearly five doctors for every 10,000 citizens. That ratio is low by regional standards, which has led to a high level of medical staff burn out and a medical service of very poor quality. (WHO, 2020)

Also, in the 2020-21 budget approved in April, 3.65% of the country's gross domestic product encompasses spending on health, pre-college and higher education, and scientific research, instead of the 10% mandated by the constitution. (AlArabi, 2021)

These different factors in return led to a high level of dissatisfaction among doctors as well as patients. So, it was inevitable to develop and implement new techniques of administration within different healthcare facilities to face these challenges, for example the integration of information technology, revenue cycle management, continuous quality improvement and different aspects of clinical governance.

Scally (1998) defined clinical governance as a framework through which healthcare organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical care will flourish.

Halligan et al (2001) and Maria Lucia (2015) in two different studies showed that the implementation of clinical governance is a key feature for continuous improvement of healthcare quality.

Patel (2021) showed that application of clinical governance key features will foster a safer, more effective clinical environment which will safeguard and promote a high quality of care for our deserving patients.

Implementing clinical governance principles in the administration of the different healthcare facilities in Egypt may have a crucial and vital impact in improving the quality of the provided medical services and closing the gap between the demand and the available resources.

- **Importance of the Study**

To clarify the urgent need for implementing clinical governance pillars within different healthcare facilities in Egypt which in turn will guarantee good quality of the healthcare services and the process of its continuous improvement.

- **Research question**

Does the application of clinical governance pillars within the healthcare facilities influence the quality of the healthcare services provided?

- **Objectives of the study**

1. To clarify the main domains of clinical governance and the history of clinical governance applications within different healthcare systems worldwide.
2. To identify the impact of clinical governance application on optimizing different resources usage and the quality of the provided medical services.
3. To determine the impact of clinical governance application on the level of satisfaction between the healthcare personnel and the patients.
4. To provide recommendations about the application of clinical governance in Egypt.

Research Methodology

- **Research approach:**

- A quasi-experimental study because it is used to determine the outcomes related to clinical governance application within nine hospitals (single case) in port said governorate and compare them to the outcomes within the period before its application.
- These hospitals contain 31 operating rooms, 267 inpatient beds and 83 Intensive care beds serving about 700,000 citizens in different medical fields.
- The mean value of fifteen key performance indicators of nine different hospitals were collected over a period of eighteen months (before and after the application of clinical governance).

- **Research tools & design**

- Data on fifteen key performance indicators (KPIs) will be collected from the official records of each of the nine hospitals. Each hospital will submit its individual results for the 15 KPIs. Subsequently, the mean values across all nine hospitals will be calculated monthly to provide a consolidated measure for each indicator.
- The indicators will be categorized into two timeframes: the pre-implementation phase of clinical governance (January 2022 to September 2022) and the post-implementation phase (October 2022 to June 2023).
- The average values of the two different periods will be compared to evaluate the effect of clinical governance implementation on the quality of the healthcare services provided.
- Hospital admission rate was determined as the total number of admissions recorded within the hospital during a given month.
- Number of the radiological examinations done throughout the month.
- Number of laboratory tests was calculated by counting all laboratory investigations performed in the hospital throughout the month.
- The whole hospital mortality rate after 24 hours of admission is defined as the proportion of patients who die in the hospital more than 24 hours after their admission, relative to the total number of hospital admissions within the same period. This indicator excludes deaths occurring within the first 24 hours of admission to avoid bias from patients admitted in a

terminal state or with non-modifiable outcomes. The rate is calculated using the following formula:

$$\text{Hospital Mortality Rate (>24h)} = \frac{\text{Number of in-hospital deaths occurring after 24 hours of admission}}{\text{Total number of hospital admissions}} \times 100$$

- The average length of stay (ALOS) is defined as the mean number of days that patients spend in the hospital from the time of admission to the time of discharge. It serves as an important indicator of hospital efficiency, bed utilization, and overall quality of care. The calculation is performed using the following formula:

$$\text{Average Length of Stay (ALOS)} = \frac{\text{Total number of inpatient days for all discharged patients during a given period}}{\text{Total number of discharges (including deaths) during the same period}}$$

- The occupancy rate is defined as the proportion of available hospital bed-days that are actually utilized by admitted patients during a specified period. It reflects the efficiency of hospital bed management and the balance between demand and capacity. The calculation is expressed as:

$$\text{Occupancy Rate (\%)} = \frac{\text{Total inpatient days during a given period}}{\text{Total available bed-days during the same period}} \times 100$$

- The bed turnover rate is defined as the number of times a hospital bed is occupied by different patients monthly. It reflects the frequency with which hospital beds are used and indicates the efficiency of bed utilization and patient flow. The calculation is expressed as:

$$\text{Bed Turnover Rate} = \frac{\text{Number of discharges (including deaths) during a given period}}{\text{Total number of available beds}}$$

- The surgical site infection (SSI) rate is defined as the proportion of patients who develop an infection at the surgical site within 30 days of the operation (or within 90 days if an implant is placed), relative to the total number of surgical procedures performed during the same period. The formula is:

$$\text{SSI Rate (\%)} = \frac{\text{Number of surgical site infections identified within the surveillance period}}{\text{Total number of surgical procedures performed in the same period}} \times 100$$

- The hospital-acquired pneumonia (HAP) rate is defined as the proportion of inpatients who develop pneumonia 48 hours or more after hospital admission, The calculation is expressed as:

$$\text{HAP Incidence Density} = \frac{\text{Number of HAP cases}}{\text{Total patient-days (or ventilator-days)}} \times 1000$$

- The 30-day hospital readmission rate is defined as the proportion of patients who are readmitted to the hospital for any cause within 30 days of being discharged from a prior hospitalization. The calculation is expressed as:

$$\text{Readmission Rate (30 days) \%} = \frac{\text{Number of patients readmitted within 30 days of discharge}}{\text{Total number of discharges (including deaths excluded, if specified)}} \times 100$$

- The ER readmission rate within 72 hours is defined as the proportion of patients who return to the emergency department for evaluation or treatment within 72 hours of their initial ER visit. The formula is:

$$\text{ER Readmission Rate (72 hrs) \%} = \frac{\text{Number of patients who revisit the ER within 72 hours of the initial visit}}{\text{Total number of ER visits during the same period}} \times 100$$

- The surgical procedures rate is defined as the proportion of patients undergoing surgical operations in relation to the total number of hospital admissions during a specified period. It is an indicator of hospital case-mix, surgical service utilization, and resource demand. The formula is:

$$\text{Surgical Procedures Rate (\%)} = \frac{\text{Number of surgical procedures performed during a given period}}{\text{Total number of hospital admissions in the same period}} \times 100$$

- The deferred surgical procedures rate is defined as the proportion of scheduled surgical operations that were postponed or cancelled after being listed, relative to the total number of surgeries scheduled during the same period. The formula is:

$$\text{Deferred Surgical Procedures Rate (\%)} = \frac{\text{Number of scheduled surgical procedures that were deferred or cancelled}}{\text{Total number of scheduled surgical procedures}} \times 100$$

- Patient experience and healthcare personnel satisfaction rates were evaluated using standardized and validated survey instruments. The surveys were administered systematically, and responses were analyzed to generate mean scores and percentage satisfaction levels, providing quantifiable measures of both patient and staff perceptions of healthcare quality.(Attachment 1)

- **Sample size**

The study compared nine pre-implementation months (January–September 2022) with nine post-implementation months (October 2022–June 2023); therefore, the sample size was fixed by the time window (census of available months) at $n = 9$ per group (total 18 monthly observations per KPI).

To verify adequacy, we used the standard two-sample comparison formula to estimate the number of observations per group required to detect a minimally important difference Δ at $\alpha = 0.05$ (two-sided) and 80% power:

$$n_{\text{per group}} = 2 \times \frac{(z_{1-\alpha/2} + z_{1-\beta})^2 \sigma_p^2}{\Delta^2}, \quad \text{with } \sigma_p^2 = \frac{\sigma_1^2 + \sigma_2^2}{2}$$

where $z_{1-\alpha/2}$ and $z_{1-\beta}$ are the normal quantiles for type-I error and power, σ_1, σ_2 are the pre/post standard deviations, and Δ is the targeted difference.

Because the five primary KPIs were **non-normally distributed** and analyzed with the **Mann–Whitney U test**, we applied the usual efficiency adjustment (asymptotic relative efficiency ≈ 0.864):

$$n_{\text{MW}} = \frac{n_{\text{t-test}}}{0.864}$$

Using observed variability for planning, this check showed that $n = 9$ per group provides $\geq 80\%$ power for the larger effects (e.g., occupancy rate and 30-day readmission), while smaller effects (e.g., SSI) would require larger n .

- **Statistical analysis of the data**

Data was fed to the computer and analyzed using IBM SPSS software package version 20.0. (Armonk, NY: IBM Corp). The Shapiro-Wilk test was used to verify the normality of distribution. Quantitative data were described using range (minimum and maximum), mean, standard deviation, median and interquartile range (IQR). The significance of the results obtained was judged at the 5% level.

- **The tests used were:**

- Student t-test: For normally distributed quantitative variables, to compare between two studied groups.
- Mann Whitney test: For abnormally distributed quantitative variables, to compare between two studied groups.

Ethical Considerations

The present study was undertaken at the administrative level and did not involve any direct patient participation, clinical interventions, or the collection of personal health identifiers. All data analyzed were aggregated hospital performance indicators derived from existing institutional records, thereby ensuring strict preservation of confidentiality and privacy. Formal approval for the conduct of the research was obtained from the relevant institutional review authority, and the study was carried out in full compliance with the ethical principles outlined in the Declaration of Helsinki and subsequent amendments. The investigation was conducted exclusively for scholarly purposes, with no conflicts of interest, financial or otherwise, and without any potential for harm to patients, healthcare staff, or participating institutions

Results

This study compared fifteen performance indicators across nine hospitals in Port Said before (January–September 2022) and after (October 2022–June 2023) clinical governance (CG) implementation.

No significant change was observed in admission rates ($p = 0.105$), with the hospitals maintaining ~90% market share. Laboratory test volumes increased significantly post-CG ($p = 0.004$), while radiology test volumes and hospital mortality after 24 hours showed no significant change ($p = 0.105$ and $p = 0.074$, respectively). (Figure 1) (table 1)

Table 1: Statistical Analysis of Key Performance Indicators Before and After Clinical Governance Implementation.

	Before CG application (n = 9)	After CG application (n = 9)	Test of Sig.	P
Hospital admission rate.				
Min. – Max.	273.8 – 391.2	310.0 – 454.1	t= 1.717	0.105
Mean ± SD.	341.8 ± 36.78	372.9 ± 40.09		
Number of laboratory tests.				
Min. – Max.	10073.0 – 14473.3	11882.9 – 15078.2	t= 3.321*	0.004*

Mean $\pm$ SD.	12412.6 $\pm$ 1369.7	14280.5 $\pm$ 985.4		
Number of radiological tests.				
Min. – Max.	2521.3 – 3328.6	2714.8 – 3415.9	t= 1.222	0.239
Mean $\pm$ SD.	2939.9 $\pm$ 271.3	3085.2 $\pm$ 231.8		
The ratio of whole hospital mortality rate after 24 hours of admission.				
Min. – Max.	0.21 – 0.40	0.17 – 1.93	t= 2.047	0.074
Mean $\pm$ SD.	0.27 $\pm$ 0.06	0.74 $\pm$ 0.68		
Average length of stay				
Min. – Max.	3.99 – 4.51	4.15 – 5.08	t= 3.022*	0.008*
Mean $\pm$ SD.	4.26 $\pm$ 0.19	4.57 $\pm$ 0.24		
Occupancy rate.				
Median [IQR]	71.6 [69.6 – 75.1]	83.0 [80.7 – 84.0]	U= 9.000*	0.004*
Bed turnover rate.				
Min. – Max.	5.31 – 6.74	5.13 – 6.65	t= 0.591	0.562
Mean $\pm$ SD.	5.94 $\pm$ 0.52	6.08 $\pm$ 0.50		
Surgical site infection rate.				
Median [IQR]	0.31 [0.007 – 0.80]	0.40 [0.38 – 0.62]	U= 39.000	0.931

Hospitals acquired pneumonia rate.				
Median [IQR]	0.0031 [0.0014 – 0.0051]	0.0085 [0.0035 – 0.22]	U= 18.500*	0.050*
Readmission rate within 30 days of discharge.				
Median [IQR]	0.13 [0.044 – 0.28]	0.49 [0.36 – 0.72]	U= 10.000*	0.006*
E.R readmission within 72 hrs				
Median [IQR]	0.52 [0.45 – 0.64]	1.18 [0.65 – 2.09]	U= 16.000*	0.031*
Surgical procedures rate				
Min. – Max.	167.9 – 263.2	178.4 – 267.9	t= 1.677	0.113
Mean ± SD.	215.9 ± 30.69	238.3 ± 25.73		
Deferred surgical procedures				
Min. – Max.	2.67 – 8.22	3.11 – 7.56	t= 0.573	0.575
Mean ± SD.	4.75 ± 1.66	5.17 ± 1.44		
Patient experience within the facility				
Min. – Max.	90.0 – 93.0	90.0 – 94.0	t= 0.434	0.670
Mean ± SD.	91.67 ± 1.0	91.89 ± 1.17		
The degree of healthcare personnel satisfaction				

Min. – Max.	88.0 – 91.0	89.0 – 92.0	t= 0.821	0.424
Mean ± SD.	89.78 ± 1.09	90.22 ± 1.20		

SD: Standard deviation, **t:** Student t-test, **U:** Mann Whitney test, **p:** p value for comparing between the two studied groups, **statistically significant** at $p \leq 0.05$.

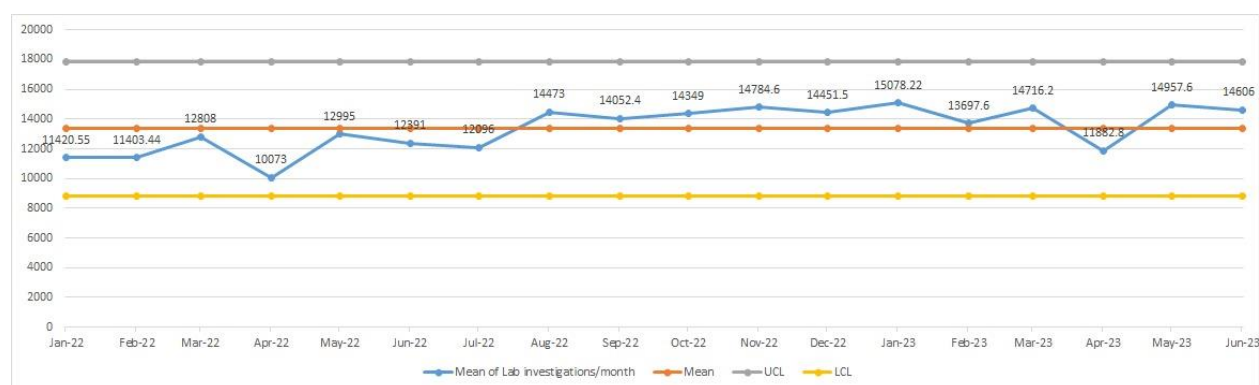


Figure 1: control chart of the mean value of the performed laboratory tests.

(**UCL:** upper control limit, **LCL:** lower control limit)

Occupancy rates and average length of stay both rose significantly after CG implementation ($p = 0.004$ and $p = 0.008$, respectively). Bed turnover rate, surgical procedure rate, deferred surgeries, and surgical site infection rates showed no significant differences. (Figure 2,3)

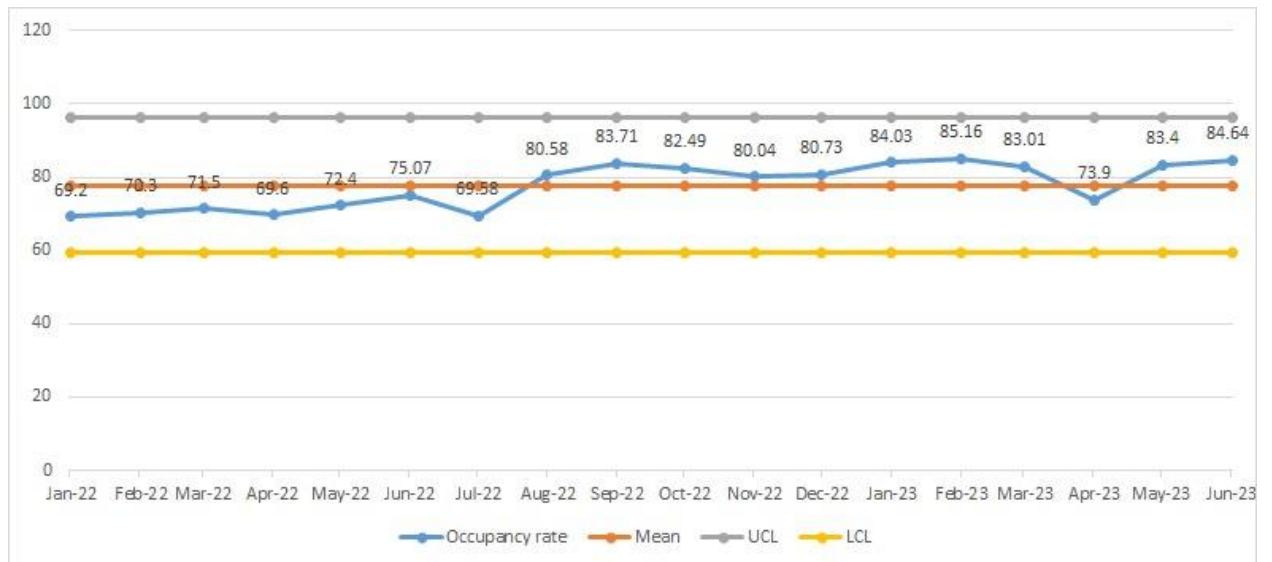


Figure 2: Control chart of the occupancy rate.

(UCL: upper control limit, LCL: lower control limit)

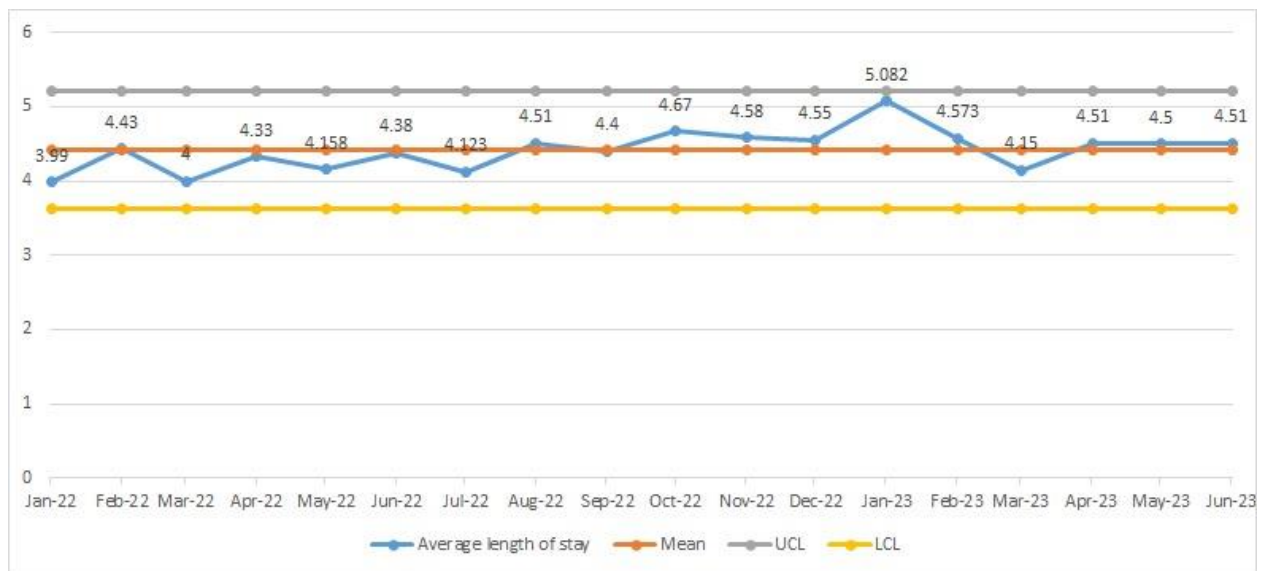


Figure 3: control chart of average length of stay.

(UCL: upper control limit, LCL: lower control limit)

Hospital-acquired pneumonia increased significantly ($p = 0.050$). Readmissions within 30 days and emergency readmissions within 72 hours also rose significantly ($p = 0.006$ and $p = 0.031$), though control chart analysis indicated pre-existing upward trends. (Figure 4.5)

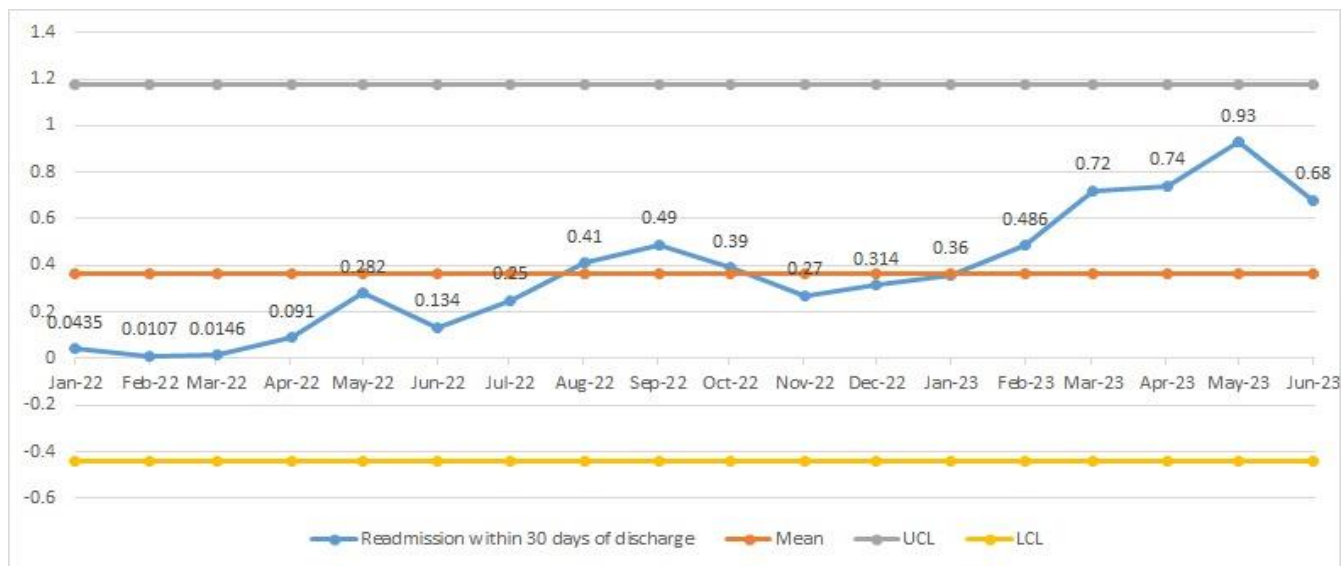


Figure 4: Control chart of the readmission rate within 30 days of discharge.

(UCL: upper control limit, LCL: lower control limit)

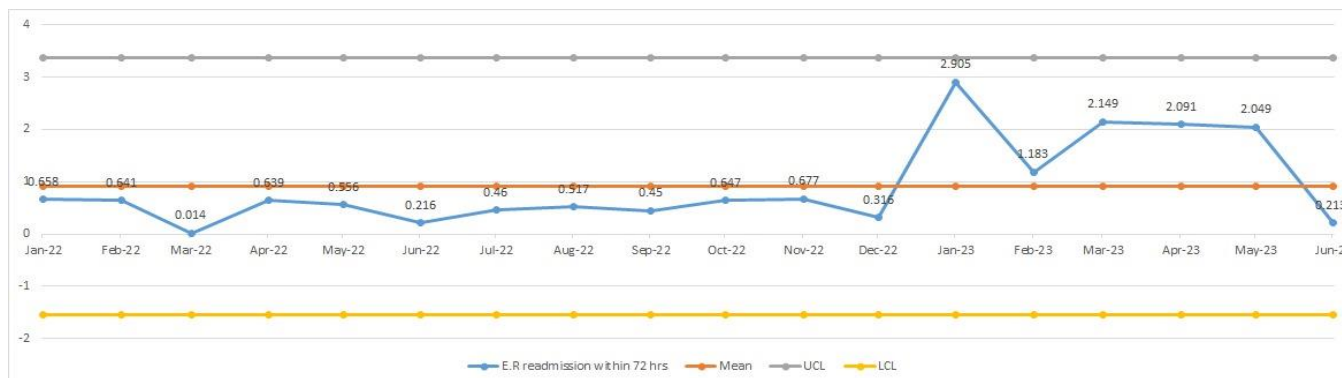


Figure 5: control chart of E.R readmission within 72 hrs.

(UCL: upper control limit, LCL: lower control limit)

Patients experience scores were comparable between groups ($p = 0.670$), and healthcare personnel satisfaction remained high in both periods (89.78 vs. 90.22).

Discussion

The current study evaluated the impact of clinical governance (CG) implementation on multiple healthcare performance indicators across participating hospitals. Laboratory performance demonstrated statistically significant improvement, with increased test volumes sustained since August 2022, reflecting enhanced efficiency, equipment utilization, and workforce productivity (Neetz, 2023).

Hospital occupancy rates and length of stay both increased after CG introduction, indicating greater resource utilization (Lechintan, 2017; Eskandari, 2022), while bed turnover rates remained unchanged (Aloh, 2020). This suggests that despite higher patient load and prolonged stays, hospital resources were managed effectively. Surgical site infection rates showed no statistically significant change, reflecting the presence of standardized preventive protocols and well-established infection control measures (Gocan, 2017).

In contrast, hospital-acquired pneumonia rates rose significantly, with a marked spike in February 2023, underscoring the need for strengthened infection surveillance and prevention strategies (Ilker, 2008). Readmission rates within 30 days (Shaw, 2020; Stefan, 2013) and emergency readmissions within 72 hours also increased; however, trend analysis indicated that these rises began before CG implementation and may be attributable to improved reporting, enhanced monitoring, and patient follow-up systems (Barzegari, 2017).

Patient satisfaction increased markedly to 91%, surpassing reported national averages (Farghaly, 2021; Metwally, 2014), while healthcare personnel satisfaction remained high. These outcomes align with existing evidence that staff engagement positively influences patient care quality and safety (Sherwood, 2013; Blizzard, 2005; WHO, 2020). The sustained high satisfaction levels may reflect the commitment of the healthcare authority to implementing the standards of the General Authority for Healthcare Accreditation and Regulation (GAHAR).

Overall, the findings suggest that CG implementation was associated with improvements in key performance indicators, patient experience, and staff engagement, despite some increases in adverse clinical outcomes that require targeted quality improvement interventions.

Conclusions & Recommendation

- **Conclusion**

The current study demonstrates that clinical governance was associated with measurable shifts in hospital performance during its early application. However, given the single-governorate scope and short follow-up, the findings cannot be generalized nationwide. Broader and longer-term evaluations are required to confirm the sustained impact of clinical governance in Egypt.

- **Recommendations**

- Establish a dedicated body within the healthcare system to oversee and ensure the proper and sustained implementation of clinical governance across facilities.
- Promote the adoption of electronic medical records and the free flow of information to support data-driven decision-making, accurate monitoring, and timely quality improvement.
- Conduct further multicenter and multi-governorate studies with longer follow-up to generate more accurate and generalizable evidence on the impact of clinical governance.

- **Limitation of the study**

- The study only focused on healthcare authority affiliated hospitals, so the results may not be applicable to other types of healthcare institutions which may limit the generalizability of the findings to other hospital settings or healthcare systems.
- The recent application of clinical governance science October 2022 does not permit monitoring over a significant period (only nine months).
- Paper recording and failure to follow the accuracy of electronic recording led to extreme difficulty in collecting and analyzing data needed.
-

Attachments

- Attachment 1

Healthcare personnel satisfaction survey

استمارة قياس رضا العاملين

م	السؤال	لا أوافق	أوافق	أوافق بشدة
1	أداة المنشأة داعمة لك			
2	أعمل في القسم المناسب لي وأشعر أنه يناسب تخصصي			
3	أقوم بتنفيذ المهام المطلوبة مني بأداء عملي			
4	أشعر أنني أحقق من خلال عملي الجهود في هذا المستشفى			
5	أشعر أن المدير المباشر لي يعاملني باحترام واحترافية			
6	أجد الفرص الكافية للتدريب والتطوير بما يتوافق مع طبيعة عملي			
7	أشعر أن رئيس القسم يتعامل مع الموظفين بشكل عادل			
8	أشعر أن الإدارة العليا تساعد على القيام بالعمل بشكل جيد			
9	أشعر أنني راضٍ عن مرتبي الحالي			
10	أجد أن وظيفتي تتطلب مجهوداً بدنياً			
11	أشعر بالفخر لأنني أُنتمي إلى هذا المستشفى			
12	أنا فاعل في عملي ضمن فريق متعاون			
13	أجد أن بيئة العمل توفر لي الظروف المناسبة			
14	أشعر بأن عملي يحقق لي التوازن بين حياتي العملية والشخصية			
15	مجموعة العمل تساعدني وتوفر لي الدعم المطلوب لأداء عملي			
16	أوصي الآخرين بالانضمام إلى هذه المنشأة كمكان جيد للعمل			

• Attachment 2

Patient satisfaction survey

استمارة قياس رضا المتنتعين

(الأقسام الداخلية)

م	السؤال	ضعيف	مقبول	جيد	جيد جدا	ممتاز
1	ما مدى رضاك عن سرعة إنهاء إجراءات الدخول للمستشفى؟					
2	ما مدى رضاك عن وقت الانتظار حتى تم تخصيص سرير لك بعد وصولك من الاستقبال عن طريق الطوارئ أو العيادة الخارجية؟					
3	ما مدى رضاك عن سهولة إجراءات الانتقال للغرفة بعد إنهاء إجراءات الدخول؟					
4	ما مدى رضاك عن مستوى نظافة الغرفة (النظافة العامة - الأثاث - دورة المياه)؟					
5	ما مدى رضاك عن التهوية ودرجة الحرارة والإضاءة داخل الغرفة؟					
6	ما مدى رضاك عن تعامل طاقم التمريض معك أثناء إقامتك (الاستجابة لطلباتك - شرح الإجراءات - إخطائك الدواء في مواعيد)؟					
7	ما مدى رضاك عن تعامل الأطباء معك أثناء إقامتك (التواصل - شرح حالتك - إخطائك المعلومات الكافية)؟					
8	ما مدى رضاك عن مستوى التقنية (الوجبات - الكنية - الجودة - الضم)؟					
9	ما مدى رضاك عن خدمات الصيانة داخل الغرفة؟					
10	ما مدى رضاك عن مستوى الأمان داخل الغرفة (التجهيزات - الكهرباء - الأدوات الطبية)؟					
11	ما مدى رضاك عن سهولة التواصل مع إدارة المستشفى عند الحاجة لذلك؟					
12	ما مدى رضاك عن تعامل موظفي الأمن داخل المستشفى؟					
13	ما مدى رضاك عن نظافة دورات المياه العامة داخل المستشفى؟					
14	ما مدى رضاك عن توافر لوحات إرشادية كافية لتوضيح أماكن تقديم الخدمة؟					
15	ما مدى رضاك عن وضوح اللوحات الإرشادية وسهولة قراءتها؟					
16	هل تقوى العودة لاستخدام خدمات الأقسام الداخلية بالمستشفى مستقبلاً؟					

استمارة قياس رضا المتنتعين

(الأقسام الخارجية)

م	السؤال	ضعيف	مقبول	جيد	جيد جدا	ممتاز
1	ما مدى رضاك عن سهولة إجراءات التسجيل (الاستقبال) في هذا المستشفى؟					
2	ما مدى رضاك عن وقت الانتظار حتى تحصلت على الخدمة؟					
3	ما مدى رضاك عن مستوى النظافة داخل العيادة الخارجية؟					
4	ما مدى رضاك عن توفر الأدوية والمستلزمات الطبية (التحاليل والفحوصات)؟					
5	ما مدى رضاك عن توفر الأطباء والفريق الطبي المعالج؟					
6	ما مدى رضاك عن مهارة وكفاءة الأطباء في أداء الخدمة؟					
7	ما مدى رضاك عن مستوى تعامل الأطباء معك واحترامهم لخصوصيتك؟					
8	ما مدى رضاك عن مهارة وكفاءة التمريض أثناء تقديم الخدمة؟					
9	ما مدى رضاك عن مستوى تعامل التمريض معك أثناء تلقي الخدمة؟					
10	ما مدى رضاك عن توافر الفصوصية أثناء تلقي الخدمة الطبية داخل المستشفى؟					
11	ما مدى رضاك عن توافر التجهيزات والأدوات الطبية بشكل يسمح بتقديم الخدمة بشكل جيد؟					
12	ما مدى رضاك عن تعامل موظفي الأمن معك؟					
13	ما مدى رضاك عن مستوى نظافة دورات المياه؟					
14	ما مدى رضاك عن توافر لوحات إرشادية كافية لتوضيح أماكن تقديم الخدمة؟					
15	ما مدى رضاك عن وضوح اللوحات الإرشادية وسهولة قراءتها؟					
16	ما مدى رضاك عن سهولة الوصول إلى العيادة الخارجية (مثل: مدخل، مصاد، ممرات)؟					

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