REDUCING CLIENT WAITING TIME IN OUT-PATIENT DEPARTMENT AT KARUGUTU HEALTH CENTRE IV NTOROKO DISTRICT

BY

MBALIBULHA METUSERA MWEMERCE

MEDIUM-TERM FELLOW (HEALTH SERVICE IMPROVEMENT)

SUPERVISORS

DR. OLIKO OKUI – MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH
DR. SIMON SSSENTAMU KADDU – NTOROKO DISTRICT LOCAL GOVERNMENT

FEBRUARY 2015
# TABLE OF CONTENTS

TABLE OF CONTENTS........................................................................................................... i

DECLARATION ....................................................................................................................... iii

ACKNOWLEDGEMENT ......................................................................................................... iv

EXECUTIVE SUMMARY/ABSTRACT .................................................................................. v

INTRODUCTION AND BACKGROUND .............................................................................. 1

LITERATURE REVIEW ......................................................................................................... 2

STATEMENT OF THE PROBLEM ...................................................................................... 3

  Problem Identification ....................................................................................................... 3
  Justification/Rationale ...................................................................................................... 5

PROJECT OBJECTIVES ....................................................................................................... 6

  General Objective ........................................................................................................... 6
  Specific Objectives .......................................................................................................... 6

INTERVENTIONS .................................................................................................................. 7

PROJECT OUTCOMES ......................................................................................................... 10

LESSONS LEARNT AND CHALLENGES ......................................................................... 12

  LESSONS LEARNT .......................................................................................................... 12
  CHALLENGES ................................................................................................................ 12

CONCLUSION, RECOMMENDATIONS AND NEXT STEPS ........................................... 13

  CONCLUSION ................................................................................................................ 13
  RECOMMENDATIONS .................................................................................................... 13
  NEXT STEPS .................................................................................................................. 13

REFERENCES ..................................................................................................................... 14
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Ante-natal care</td>
</tr>
<tr>
<td>ART</td>
<td>Ant-retroviral treatment</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuous professional development</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Officer</td>
</tr>
<tr>
<td>DPT3</td>
<td>Diphtheria Pertusis Tetanus 3</td>
</tr>
<tr>
<td>H/C</td>
<td>Health centre</td>
</tr>
<tr>
<td>INPD</td>
<td>In-patient department</td>
</tr>
<tr>
<td>Mark-SPH</td>
<td>Makerere University School of Public Health</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
</tr>
<tr>
<td>OPD</td>
<td>Out –patient department</td>
</tr>
<tr>
<td>PFP</td>
<td>Private for profit</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private not for profit</td>
</tr>
<tr>
<td>RCT</td>
<td>Routine counseling and testing</td>
</tr>
<tr>
<td>Q/I</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>DHT</td>
<td>District Health Team</td>
</tr>
<tr>
<td>HUMC</td>
<td>Health Unit Management Committee</td>
</tr>
<tr>
<td>LAB</td>
<td>Laboratory</td>
</tr>
<tr>
<td>REG</td>
<td>Registration</td>
</tr>
<tr>
<td>INJ</td>
<td>Injection Room</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
</tr>
</tbody>
</table>
DECLARATION
I, Mbalibulha Metusera Mwemerce, do hereby declare that this end of project report entitled, Reducing client long waiting duration in Out Patient Department at Karugutu H/CIV, has been prepared and submitted in fulfillment of the requirements of the Medium-term Fellowship Program at Makerere University School of Public Health and has not been submitted for any academic or non-academic qualifications.

Signed…………………………… Date………………………………………………

Mbalibulha Metusera Mwemerce,
Medium-Term Fellow

Sign…………………………… Date………………………………………………

Dr Simon Ssentamu Kaddu
Institution Mentor

Sign…………………………… Date………………………………………………

Dr. Olico Okui
Academic Mentor
ACKNOWLEDGEMENT
I hereby acknowledge the staff of Karugutu HC IV for their contribution towards the success of this project. Specifically I thank, Daaki Judith Amanyire, Kyakimwa Grace, Badaki Richard, Magezi Chris, Asimwe Richard, and Rude Wilson. I also thank the administration of Ntoroko District and staff in the DHO’s office (Bahati Enock and Muhindo Francis), for their guidance and support as well as Masereka Selevest of Uganda Wildlife Authority for his support in all this work.

Special thanks go to the Makerere University School of Public Health – CDC Fellowship programme for their financial and technical support.

Appreciation also goes to the academic mentors Dr. Olico Okui, Dr.Gwokyalya Violet, Dr.Ibrahim Kirunda and Mr.Matovu KB Joseph.

Finally, I thank my fellow Fellows for their insightful contribution to this project.
EXECUTIVE SUMMARY/ABSTRACT

Long waiting duration has been a challenge in most health care settings for a long time. It leads to patient dissatisfaction, prolongs the work flow processes, affects client general health and may lead to unnecessary death if not addressed.

This project set out to reduce waiting time from 5 to 2 hours in the Out Patient Department (OPD) at Karugutu HCIV by December 2014. This has been achieved by orienting all health workers to improve the triage process, creating smooth client flow to enable all OPD clients move through all service points of care within 2 hours, developing and enforcing an efficient duty roster to ensure that health workers man the stations as required. The project also provided break tea to minimize movement of staff in search of refreshments (as majority of them are not accommodated on site so move very early and for very long distances to come for work) and provision of differentiated client cards, labeling the various service points to enable clear and quick identification, regularizing staff meetings, implementation of 5S and conducting regular supportive supervision.

The project utilized participatory methods to ensure involvement of all staff and ownership of project activities and eventually sustainability. This and other interventions implemented have not only improved the waiting time to 2 hours and less but has also improved client – service provider relationships at Karugutu HCIV, hence service improvement.

However, challenges like resistance from some staff, intimidation of team members, late coming for duty by some staff, were experience and threatened the continuity of the interventions; the required the intervention of the district administration. We also employed remedial measures like orientation of staff on QI concepts and objectives, team work, re-scheduling of the remaining staff to bridge the gap, to address the challenges.

Incorporation of this program into the budgets of the facility, continuous team building, mentorships and lobbying for financial support from implementing partners, will help us sustain the program reduction of long waiting duration of clients.
INTRODUCTION AND BACKGROUND

Ntoroko District was carved out of Bundibugyo District in 2010. It serves a population of 98,800 people (51,448 females, 47,352 males) (source District population Office). It has one (1) county, ten (10) sub-counties, forty nine (49) parishes and two hundred two (202) villages.

The district is predominantly an agricultural area in the greater Karugutu and cattle keeping in the greater Rwebisengo and fishing is done along the shores of Lake Albert.

The district has one Health Centre IV, two H/C IIs and three H/C IIs. It has one Private Not for Profit (PNFP) and two Private for Profit (PFP). Being a mountainous district in the Rwenzori region, Ntoroko district is among the hard to reach districts of Uganda with poor road network especially those leading into the rural areas. During rainy seasons, the greater Rwebisengo gets flooded making it difficult to deliver health services.

Karugutu H/C IV is one of the health facilities in Ntoroko district and is along Bundibugyo-Fort-portal highway about 28 kms from Fort -Portal. It is found in Karugutu Town Council and is the highest government referral facility. It has a population of 22,483 people and its catchment area covers the entire district. It offers Out Patient Services, comprehensive HIV, MCH, laboratory services admits clients for inpatient care, Health Education, immunization services, malnutrition assessment, minor surgery and referral services. OPD daily attendance ranges from 70 to 100 clients.

The outpatient department experience long waiting time sometimes up to 7 hours. Majority of patients wait for an average of 5 hours to receive the required services. This leads to delayed access to care & treatment and late referral of patients to other health facilities for further clinical management.

MoH recommends that client waiting time should 2 hours which, if adhered to, leads better health outcomes, confidence building and improved health seeking behavior among clients. OPD being the entry point of the facility, provides a snapshot of the quality of care offered at a facility.

It is therefore against this background that the project sought to put in place mechanisms to reduce this very long waiting time.
LITERATURE REVIEW

The amount of time a patient spends at a health facility has often been used as a measure of patient satisfaction with the service being provided. A patient’s experience of waiting can radically influence his/her perceptions of service quality (Afolabi & Erhun, 2003). In a study carried out at the University of Southern California, Los Angeles, USA, it was shown that the overall satisfaction of patients with medical services is closely related to their satisfaction with waiting time (Trop J Pharm Res, June 2003). Waiting time also leads to unnecessary delays in assessment leading to worsening conditions and death.

Additionally, waiting time becomes a factor in retaining current users of the services. Healthcare systems throughout the world face long and increasing wait times for medical services (Willcox et al. 2007; Siciliani and Hurst 2004; Hurst and Siciliani 2003; Blendon 2002). Sometimes these waits may have little medical impact, but excessive delays may be detrimental to patients’ health (CIHR 2007). As a result, there is growing public and patient pressure to reduce wait times to acceptable levels of quality of health care.

This therefore confirms that there is need to improve quality of service through reduction of waiting time which ensures that clients are provided with the time and care they require. However this can only happen if there are deliberate efforts to address it.
STATEMENT OF THE PROBLEM
The problem of long waiting time in the OPD OF Karugutu HC IV was identified through mini
time and motion study done by the project team which revealed that on average; a client spends
an average of five hours to receive the required services. The biggest point of delay was while
clients waited to be seen by the clinicians and while they waited to be served by the Laboratory.
Quite often client gave up on receiving services after waiting for too long while others kept
around but complaining. A crowd of over 50 patients confronted the unit In Charge in 2013 and
early 2014 about the long time spent at the facility. Further analysis showed that the main cause
of this was late arrival by staff, early signing off and general absenteeism of service providers
with no one following up or taking up the responsibility to allocate duties and ensure that the
staff who were around could share the tasks and have patients served. The problem of long
waiting time had been present for quite some time and a few strategies had been implemented
before like; putting in place a duty roaster & staff daily attendance book, plus general staff
meetings but all these did not help much specifically because theyhad not been followed up and
staff had not been involved.

Problem Identification
Following the first module of the health service improvement course, a meeting was held with
the District Health Team (DHT) members mainly to explain the purpose and contents of this
course which was continuous quality improvement course (CQI) to improve health service
delivery. This was followed by a general meeting at the health facility to explain the course and
introduce the CQI project as well as to identify the major pressing health facility issues in need
of urgent attention. Among the problems identified was low DPT 3 and measles coverage, long
waiting duration in OPD, poor waste disposal, non recovery of patients in the inpatient
department, late coming of staff, poor record keeping, poor medicine storage, poor hygiene and
sanitation in wards, and lack of adequate care given to malnourished children. The problems
were scored and the major problem identified prioritized through voting was “long waiting time
at OPD’ as seen in the table below:
<table>
<thead>
<tr>
<th>Issue</th>
<th>No. of voters (out of 22)</th>
<th>% Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malnourished children identified during OPD</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Long waiting time at the OPD</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Low DPT3 coverage</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Low Measles coverage</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Poor waste management</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

As seen from the table above, long waiting time at the facility was the major issue that needed to be attended to if service delivery is to improve at the facility.

To establish the baseline waiting time, we followed up patients and recorded the time the client reported at the outpatient department, and the time they reported at the various service points, and the time they left each service point. We then recorded the time they left the OPD after being service. We then calculated the time taken to receive the required services at the individual stations and the time spent overall. This was done not only in OPD but we sampled patients even in other departments like immunization department, ANC, and ART Clinic. Results showed that the OPD had the longest waiting to a tune of an average of 5 hours and the points of longest waiting were as clients were waiting for the clinician and as they were waiting for laboratory investigations as shown in the graph below.

**Bar graph showing time spent at the different service points of OPD**
Justification/Rationale

The need for reducing waiting time for clients in the facility was hinged on the fact that the longer a patient stays in the queue before receiving services affects their general health. This project sought to reduce waiting time so as to attend to clients and eventually help to improve the general health of the clients. Therefore working with staff through mentorship and re-allocation of roles and enforcing supervision and use of the duty roster went a long way in helping to reduce the time a patient spent in the facility.

Root causes of long waiting time in OPD

- Late coming of health workers and leaving early before time
- Absenteeism of some health workers without informing their immediate supervisors.
- Duty roster not followed by clinical officers and laboratory
- Too many responsibilities assigned to an individual at ago thus affecting services at the health unit
- Some health workers take long time to come back during break and lunch.
- Untrained staff at triage area & lack of knowledge on 5s
- Limited clinical area.
- No flow-chart and signage’s to direct client for the various services in the health facility
- No CPD, irregular staff meetings, inadequate internal supervision, improper staff annual leave, no disciplinary committee, and working environment not conducive

The main root causes are demonstrated in the fish bone diagram below
PROJECT OBJECTIVES

General Objective
To reduce waiting time at OPD in Karugutu HCIV from an average of 5 hrs to about 2 hours by December 2014

Specific Objectives
- To streamline patient flow within the out-patient department by September 2014
- To monitor and evaluate performance of OPD staff by December 2014
- To improve the work flow in OPD by December 2014
INTERVENTIONS
The project utilized various methods, mainly participatory methods in ensuring that staff were brought on board and mentored into best practices aimed at reducing waiting time. A number of interventions were put in place including training staff on how to triage, introduction of break tea, printing and installation of signage on various duty stations, introduction of client cards, application of 5s, creation of a second clinical room, enforcement of the weekly clinical staff duty roster, negotiating with the clinical officers to have two of them on duty daily to attend to clients, ensuring internal supervision by In Charge, monthly review meetings. This required participation of all staff in order to realize positive results from the project

1. Allocation of staff to be in charge of triage
Right at the project start, we decided as a team to allocate two qualified staff, an Enrolled Nurse and a Nursing Officer to be in charge of triage so they could sort out clients according to their conditions and urgency to be worked on. These staff were then helped by the nursing assistants and volunteers.

2. Training
Staff were trained in CQI and the benefits of reducing waiting time at every point of service delivery in the facility. These staffs monitored the movements of clients from arrival to exit. At every entry point staffs noted time spent at each station and at the end of the week a report was made showing where clients spent most time. The team would then review the issues and such points so that improvements could be effected. Trainings were followed by support supervision and mentorship that helped to help staff cope with the new changes, continuously address barriers as well as support those who were resisting change.

3. Provision of Break Tea for Staff
To reduce on excuses, long tea breaks and absenteeism from duty under the disguise of having no refreshments while on duty, we provided staff break tea (an accessible kettle with sugar that staff would use to prepare their own tea) to help staff stay on duty hence reducing the waiting duration of clients in the facility. The facility administration also pledged to continue providing the sugar and some bites to accompany the tea. This intervention was well appreciated by staff.
4. **Implementation of 5S**

The team implemented the 5S in order to improve the work flow, which in turn contributed to reducing the client waiting time. Application of 5s in OPD helped us to have enough space for a second clinical room to be used by a second clinician especially that client waited longest at the clinical room all waiting to be seen by only one clinician.

5. **Defining and attending to emergencies**

The team agreed to have a definition for priority patients and these would be immediately served to avoid repercussions that may result for worsening conditions. Among the people allocated to triage one who always look out for priority patients before serving the rest. Priority patients were mainly those with danger signs like fast or difficulty in breathing, temperature $>37.5^{\circ}C$, altered level of consciousness, dehydration etc. These would be immediately seen by the clinician.

A young with high temperatures being led to the clinician.
6. Internal Support Supervision
Regular support supervision is key to high productivity and better performance by any staff member. Therefore, involvement of facility in-charge to regularly supervise and provide mentorship to staff provided the much needed cooperation of staff and improved staff performance.

7. Monthly staff meetings
We initiated monthly staff meetings which were chaired by the in-charge and were meant to share results and make decisions basing on data and reviewing interventions and therefore performance. These were originally not being held regularly. With the introduction of the project, staff meetings became a monthly activity and have led to an improvement in the responsiveness of staff and especially in working towards achieving the project objective.

8. Signage
We printed and installed labels at the different service points as shown below and this helped clients’ easy direction and flow.

9. Use of client cards
We also introduced client color cards directing them to specific points of care according to their illnesses. We educated clients (staff working with VHTs) on the role of these cards and we noted that when clients learnt their use, they helped in client flow and thus client waiting time.
PROJECT OUTCOMES
Following the above interventions, waiting time at the facility reduced as shown in the figures below.

Graphs showing situation before and after implementation of the QI project

Overall waiting time in Karugutu HC IV OPD for the period April-December 2014
Overall, a number of improvements have been registered in the facility including:

- Smooth flow of clients through OPD in Karugutu H/C 1V.
- Clients have continuously come as early as 7.00 am a sign of confidence and trust in staff and services offered.
- Facility image and performance in community improved compared to when clients used to leave the facility unsatisfied, having spent a lot of time unattended to, referring themselves to drug shops hence self medication.
- Staff improvement and effectiveness while on duty realized
- Because of this project, departmental quality improvement teams have been formed all of them now addressing service gaps in their departments.
- Due to improved performance, monthly Quality Improvement reports are submitted together with the facility monthly HMIS 105 report
LESSONS LEARNT AND CHALLENGES

LESSONS LEARNT

• A lot can be achieved through ownership and partnership with organizations with similar objectives
• Team work is a major tool to be used in order Q/I activities to be successful
• Participatory approaches lead to successful interventions

CHALLENGES

• Resistance to own the project by some staffs. There were cases of resistance among staff considering this as added work but continuous orientation and mentorship helped to allay their fears and manage expectations.
• Interdiction of some members: Some members of staff were interdicted by the government during the project period but the rest of the team worked together to achieve the intended objectives.
• There were cases of late coming of some individuals despite all interventions (especially those who travel long distances), but re-scheduling and re-allocating staff helped to bridge the gap.
• Long distances traveled in search for internet services was a challenge to regular communication with the mentors
CONCLUSION, RECOMMENDATIONS AND NEXT STEPS

CONCLUSION
Reducing waiting hours of clients has a great impact on clients’ life; and this can be successfully achieved through team work, continuous mentorship and supervision. These basic interventions indicated that it is possible to reduce waiting time for patients and that it imporves accountability, heightens awareness and gets staff engaged from the bottom to the top in trying to improve the patient experience and hence better quality service provision.

RECOMMENDATIONS
We recommend that the district strengthens support supervision at the facility in order to provide support in administrative matters. It should also strengthen the Quality improvement team at the district so that it supports the facility team.

MakSPH-CDC fellowship program should continue with the support initiated so that more members can benefit and there can be a bigger team equipped with QI skills to lead improvements at the facility and even to support lower level facilities. MakSPH-CDC fellowship program should create room for refresher courses for former fellows and provide more opportunity for other district staff to undertake this training especially the district quality improvement team.

NEXT STEPS
The team has started negotiations to incorporate quality improvement initiatives into every financial year so that interventions can be sustained. Mentorships will continue and orientation of new staff at the facility so that the changes that have been introduced can continue. We shall also lobby the implementing partners for more financial support so that even the improvements that were not prioritized in this project can be attended to.
REFERENCES